

BULLETIN

AMERICAN COLLEGE OF SURGEONS



January 2002
Volume 87, Number 1



FEATURES

Surgeons pocket PDAs to end paper chase: Part I
Karen Sandrick

12

9/11: Another reason to "ungate" health care
Lawrence A. Danto, MD, FACS

16

CPT changes in 2002

John T. Preskitt, MD, FACS, and Jean A. Harris

19

Committee keeps College fiscally prepared for the future
William F. Sasser, MD, FACS

24

DEPARTMENTS

From my perspective

Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

3

FYI: STAT

5

Dateline: Washington

Division of Advocacy and Health Policy

6

What surgeons should know about...

The 2002 Medicare fee schedule

Cynthia A. Brown

8

Keeping current

What's new in ACS Surgery: Principles and Practice

Erin Michael Kelly

27

Socioeconomic tips of the month

Internet resources for coding and reimbursement policies

28

Stephen J. Regnier
Editor

Linn Meyer
*Director of
Communications*

Diane S. Schneidman
Senior Editor

Tina Woelke
Graphic Design Specialist

**Alden H. Harken,
MD, FACS**
**Charles D. Mabry,
MD, FACS**
**Jack W. McAninch,
MD, FACS**
Editorial Advisors

Tina Woelke
Front cover design

Bernie Kagel
Back cover design

About the cover...

Many surgeons are discovering that personal data assistants (PDAs) help them to organize their schedules, billings, professional phone books, and patient information. The first of a two-part article on the proliferation of PDAs and how surgeons are using them appears on page 12 of this month's *Bulletin*. Part II of the article, which will focus on how wireless technology can be used for record-keeping, viewing digital images, and improved patient safety, will be published in the February 2002 issue.

Bulletin of the American College of Surgeons (ISSN 0002-8045) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000, fax: 312/202-5001; e-mail: postmaster@facs.org; Web site: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the authors' personal observations and do not imply endorsement by nor official policy of the American College of Surgeons.

©2002 by the American College of Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

NEWS

April 14-17, 2002: 30th Annual Spring Meeting

30

Study of volunteerism among surgeons <i>Andrew L. Warshaw, MD, FACS</i>	40
2002 Travelling Fellow selected	42
2002 International Guest Scholars selected	42
Applications being accepted for research award in academic vascular surgery	42
Credentialing, malpractice key issues at AMA meeting	43
Select postgraduate course syllabi now available on CD-ROM	43
2003 Australia and New Zealand Travelling Fellowship available	45
International Guest Scholarships available for 2003	46
ACS Scholarships, Fellowships, Award available	48
Contributions to the 2002 Surgical Forum are requested	51
Trauma committees sponsor standards course	53
Letters	56
Correction	56
Next month in JACS	60

Officers and staff of the American College of Surgeons

Officers

R. Scott Jones, MD, FACS, *Charlottesville, VA*
President
Kathryn D. Anderson, MD, FACS, *Los Angeles, CA*
First Vice-President
Claude H. Organ, Jr., MD, FACS, *Oakland, CA*
Second Vice-President
John O. Gage, MD, FACS, *Pensacola, FL*
Secretary
John L. Cameron, MD, FACS, *Baltimore, MD*
Treasurer
Thomas R. Russell, MD, FACS, *Chicago, IL*
Executive Director
Gay L. Vincent, CPA, *Chicago, IL*
Comptroller

Officers-Elect (take office October 2002)

C. James Carrico, MD, FACS, *Dallas, TX*
President
Richard R. Sabo, MD, FACS, *Bozeman, MT*
First Vice-President
Amilu S. Rothhammer, MD, FACS, *Colorado Springs, CO*
Second Vice-President

Board of Regents

Edward R. Laws, Jr., MD, FACS, *Charlottesville, VA*
Chair*
Jonathan L. Meakins, MD, FACS, *Montreal, PQ*
Vice-Chair*
Barbara L. Bass, MD, FACS, *Baltimore, MD*
L. D. Britt, MD, FACS, *Norfolk, VA*
William H. Coles, MD, FACS, *New Orleans, LA*
Paul E. Collicott, MD, FACS, *Chicago, IL*
Edward M. Copeland III, MD, FACS, *Gainesville, FL*
A. Brent Eastman, MD, FACS, *La Jolla, CA*
Richard J. Finley, MD, FACS, *Vancouver, BC*
Josef E. Fischer, MD, FACS, *Boston, MA*
Alden H. Harken, MD, FACS, *Denver, CO**
Gerald B. Healy, MD, FACS, *Boston, MA**
R. Scott Jones, MD, FACS, *Charlottesville, VA**
Margaret F. Longo, MD, FACS, *Hot Springs, AR*
Jack W. McAninch, MD, FACS, *San Francisco, CA**
Mary H. McGrath, MD, FACS, *Maywood, IL*
John T. Preskitt, MD, FACS, *Dallas, TX*
Ronald E. Rosenthal, MD, FACS, *Wayland, MA*
Maurice J. Webb, MD, FACS, *Rochester, MN*
*Executive Committee

Board of Governors/Executive Committee

J. Patrick O'Leary, MD, FACS, *New Orleans, LA*
Chair
Sylvia D. Campbell, MD, FACS, *Tampa, FL*
Vice-Chair
Timothy C. Fabian, MD, FACS, *Memphis, TN*
Secretary
Julie A. Freischlag, MD, FACS, *Los Angeles, CA*

Steven W. Guyton, MD, FACS, *Seattle, WA*
Rene Lafreniere, MD, FACS, *Calgary, AB*
Courtney M. Townsend, Jr., MD, FACS, *Galveston, TX*

Advisory Council to the Board of Regents (Past-Presidents)

W. Gerald Austen, MD, FACS, *Boston, MA*
Henry T. Bahnson, MD, FACS, *Pittsburgh, PA*
Oliver H. Beahrs, MD, FACS, *Rochester, MN*
John M. Beal, MD, FACS, *Valdosta, GA*
Harvey W. Bender, Jr., MD, FACS, *Nashville, TN*
George R. Dunlop, MD, FACS, *Worcester, MA*
C. Rollins Hanlon, MD, FACS, *Chicago, IL*
James D. Hardy, MD, FACS, *Madison, MS*
M. J. Jurkiewicz, MD, FACS, *Atlanta, GA*
LaSalle D. Leffall, Jr., MD, FACS, *Washington, DC*
William P. Longmire, Jr., MD, FACS, *Los Angeles, CA*
Lloyd D. MacLean, MD, FACS, *Montreal, PQ*
William H. Muller, Jr., MD, FACS, *Charlottesville, VA*
David G. Murray, MD, FACS, *Syracuse, NY*
David C. Sabiston, Jr., MD, FACS, *Durham, NC*
Seymour I. Schwartz, MD, FACS, *Rochester, NY*
George F. Sheldon, MD, FACS, *Chapel Hill, NC*
G. Tom Shires, MD, FACS, *Las Vegas, NV*
Frank C. Spencer, MD, FACS, *New York, NY*
Ralph A. Straffon, MD, FACS, *Shaker Heights, OH*
James C. Thompson, MD, FACS, *Galveston, TX*

Executive Staff

Executive Director: Thomas R. Russell, MD, FACS
Division of Advocacy and Health Policy:
Cynthia A. Brown, Director
American College of Surgeons Oncology Group:
Samuel A. Wells, Jr., MD, FACS, Group Chair
Communications: Linn Meyer, Director
Division of Education:
Ajit K. Sachdeva, MD, FACS, FRCSC, Director
Executive Services: Barbara L. Dean, Director
Finance and Facilities: Gay L. Vincent, CPA, Director
Human Resources: Jean DeYoung, Director
Information Services: Howard Tanzman, Director
Journal of the American College of Surgeons:
Wendy Cowles Husser, Executive Editor
Division of Member Services:
Paul E. Collicott, MD, FACS, Director
Division of Research and Optimal Patient Care:
Alden H. Harken, MD, FACS, Interim Director
Cancer:
David P. Winchester, MD, FACS, Medical Director
Office of Evidence-Based Surgery:
Margaret Mooney, MD, Interim Director
Trauma:
David B. Hoyt, MD, FACS, Medical Director
Executive Consultant:
C. Rollins Hanlon, MD, FACS

From my perspective

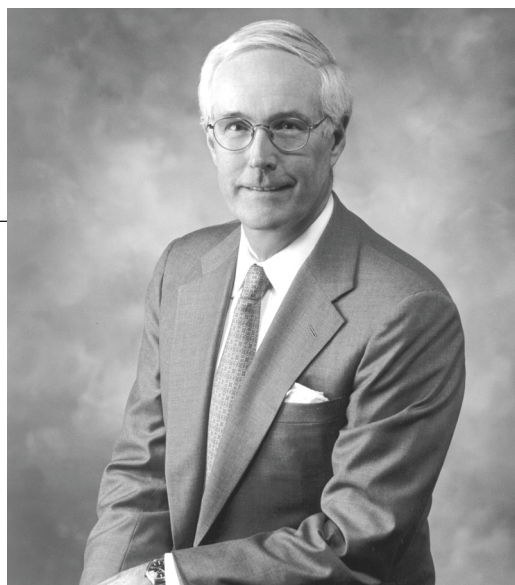
Because of the dynamic nature of medical practice today, surgeons, other physicians, health care practitioners, and medical and health-related organizations must look to the future and appropriately respond to external forces. Flexibility in managing potential change and a willingness to work cooperatively are necessities, particularly at this time.

The trends that are emerging within all segments of health care have been affecting the hospital industry for at least 10 years. Because these patterns are becoming more apparent within surgical practice, I think it's worthwhile to reflect upon what has occurred within the hospital industry in anticipation of what is likely to happen within our own component of the medical marketplace. Most significantly, individual hospitals have merged, been acquired, or been dissolved. As a result, most existing hospitals are part of large networks. Some of these mergers have been utter failures; others have resulted in systems that have successfully met the demands of local markets. Further, efforts to integrate hospitals and the cultures that developed within individual institutions have often proved difficult. It is never easy to meld different philosophies into one overarching mission or entity.

Now there is a growing need for surgeons to work cooperatively, sometimes even with nonsurgeons. And, as we develop a new paradigm of conducting business and advocating for our patients, we must be prepared to overcome the divisions that exist within our professional culture, so we can avoid some of the problems hospitals have experienced.

Merging organizational interests

Organizations such as the American College of Surgeons are working to make the transition toward a new spirit of cooperation a smooth one. In the past, there were only a limited number of groups that focused on the interests of surgeons. However, over the past few decades, numerous surgical organizations have arisen to meet the needs of a growing number of specialists. Increased specialization, unfortunately, has led to divisions within our profession and made it difficult for one organization, namely the College, to speak for all of surgery. If we are going to remain effective and carry out our mission, we will need to work in a progressive manner with the surgical specialty societies.



“Organizations like the College and individual surgeons can no longer act in isolation and expect to survive in today’s world.”

In addition, we will need to work with groups like the American Medical Association (AMA) and other medical organizations, which in the past seemed quite distant and different from the College. By working with a broad array of organizations, we will be able to form strong coalitions that can assist us in achieving our mission. Clearly, these coalitions will become more important as we move forward in addressing social and political issues. I would cite as an example the recent formation of a coalition of more than 50 medical and surgical organizations that came together to advocate passage of the Physician Payment Fairness Act of 2001, which would have significantly reduced the negative 5.4 percent Medicare physician payment update for 2002. Included along with the College in this alliance were the AMA and the major surgical specialty societies.

Just as the College is reaching out to other organizations, our individual chapters also are discovering the benefits of merging with other groups. In recent years, we have seen consolidation of various chapters and surgical societies. Again, many of these cooperative efforts would not have been possible in previous years, but current conditions and the resultant strains on time and

income have made them very reasonable and necessary.

As only a few examples of a growing trend, I would cite the merger of the Rhode Island Chapter of the College and the Providence Surgical Society, the Connecticut Chapter and the Connecticut Society of American Board Surgeons, the Metropolitan Washington, DC, Chapter and the Washington Academy of Surgery, the Upstate New York Chapter and the New York State Society of Surgeons, and the proposed merger of the Hawaii Chapter and the Hawaii Surgical Association. These are only a few examples of the growing tendency of surgical groups to come together to minimize costs and time away from practice while still achieving goals that are inherently important to the individual organizations.

Practice mergers

Surgical organizations are not alone in discovering the benefits of banding together to better carry out their missions. Practicing surgeons, too, are feeling more obliged to form partnerships. For many years, surgeons remained fiercely independent, citing that characteristic as one of the reasons they chose a career in medicine. Being individualists, surgeons often went into solo practice and enjoyed the benefit of freedom from internal disagreements and “professional divorces.” However, surgeons in solo practice also found that they had to make a full commitment to practices that truly required their attention 24 hours a day, seven days a week. Additionally, they had to tolerate fluctuating workloads, going from times of being overwhelmed clinically to clearly slow and, perhaps, disturbing periods.

Given the socioeconomic pressures that they face today, many young surgeons are increasingly attracted to group practice, which offers them more opportunities to discuss perplexing cases among peers, to form partnerships, and to establish a central team to handle billings and other details of managing a practice. Due to the bureaucracy of practice today and managed care models, it is very important that surgeons work with people who have the business acumen needed to evaluate contracts, to seek approval for procedures, and to establish internal procedures and policies that ensure the practice is properly run.

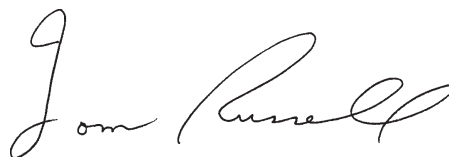
Surgeons who go into group practice also find

they are better able to meet the requirements imposed on the practice of surgery in recent years by governmental regulations. These mandates include occupational health and safety standards, special coding guidelines for evaluation and management services, general coding and compliance rules, privacy and fraud and abuse standards established under the Health Insurance Portability and Accountability Act, and on-call requirements stemming from the Emergency Medical Treatment and Labor Act. Compliance with all of these regulations takes a significant amount of time from the solo practitioner’s practice with no proven patient benefits. It is easier for group practices to keep up and to implement the expected changes.

Finally, the individual surgeon really has had little power to negotiate terms with third-party payors. However, when surgeons join forces, they can more effectively work to achieve equitable contracts. This type of strategy to bargain collectively was used to the benefit of a group of surgeons in Washington State and was described in an article written for the *Bulletin* by Robert L. Howisey, MD, FACS, and Martin B. Durtschi, MD, FACS (November 2001, p. 24).

Survival strategies

The dynamics of the health care industry have been changing rapidly over the last few decades. Hospitals no longer function independently. Similarly, organizations like the College and individual surgeons can no longer act in isolation and expect to survive in today’s world. The College is fully cognizant of these changing realities. Therefore, we are reaching out to our sister organizations and planning a wider variety of programs that will help surgeons sharpen their business acumen. By working together, we can more successfully develop programs and activities that can help our Fellows both meet and stay abreast of the challenges of these complex, and often confusing, times.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

A major goal that Thomas R. Russell, MD, FACS, Executive Director, has set for the College and himself is to bring all surgical organizations and groups related to surgery closer together. With that goal in mind, he and other College officials devote a considerable amount of time visiting ACS chapters and other groups of importance to the College. In recent weeks, R. Scott Jones, MD, FACS, ACS President, attended the meeting of the executive committee of the **Board of Governors of the American Academy of Otolaryngology-Head and Neck Surgery, Inc.** Dr. Russell met with the **Board of Directors of the American Society of Anesthesiologists** and attended the meetings of the **Arizona and Connecticut Chapters**, the **Georgia Surgical Society/Georgia Chapter**, and the **Nassau Surgical Society/Brooklyn-Long Island Chapter**. He participated in a meeting on bioterrorism sponsored by the **Association of American Medical Colleges** and attended the meetings of the **Southern Thoracic Surgical Association**, the **Western Surgical Association**, and the **Interim Meeting of the American Medical Association**. He delivered the **W. Alton Jones Lecture** at the University of Missouri, the **Edward Mason Lecture** in Washington, DC, and the **William J. Fouty Lecture**, also in Washington, DC. In addition, he hosted a **meeting of chief executive officers and other leaders from the surgical specialty societies**. The purpose of the meeting, which was held in Chicago on November 9 with approximately 40 society representatives, ACS officials, and ACS advisory council chairs in attendance, was to review issues of mutual interest, including the increasing shortage of nurses. Representatives of the Association of periOperative Registered Nurses also participated.

The College and WebMD have introduced **ACS Surgery: Principles and Practice**. Based on the former *Scientific American® Surgery*, **ACS Surgery: Principles and Practice** is a continuously updated comprehensive information system for practicing surgeons. Forming the foundation of this system is a bound volume that is supplemented with monthly updates on the Web. As a special one-time feature, this annual resource includes a CD-ROM containing the algorithms and illustrations made famous in *Scientific American Surgery*. For more information, visit: http://www.facs.org/members/acs_surgery.html.

On Wednesday, December 5, Thomas R. Russell, MD, FACS, Executive Director of the College, participated in a press conference called by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to discuss **wrong-site surgery** and steps that can be taken by health care practitioners and patients to prevent such mistakes. Other participants in the press conference were: Dennis S. O'Leary, MD, JCAHO president; S. Terry Canale, MD, immediate past-president, American Academy of Orthopaedic Surgeons; and Donald Palmisano, MD, FACS, member, board of trustees, American Medical Association. Information on the press conference and specific safety steps can be accessed at http://www.jcaho.org/news_frm.html.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Congressional proposals introduced to limit Medicare cuts

Legislation introduced in November to limit scheduled 2002 reductions in Medicare physician payments received strong support from medical and surgical specialty societies and among Members of Congress. The Medicare Physician Payment Fairness Act of 2002 was introduced November 8 by Sens. Jim Jeffords (I-VT) and John Breaux (D-LA), and on November 28 by Reps. Michael Bilirakis (R-FL) and Sherrod Brown (D-OH). The bill would have significantly reduced to -0.9 percent the -5.4 percent Medicare physician payment update that took effect January 1, 2002. It also would have required the Medicare Payment Advisory Commission to conduct a study and prepare a report by March, offering its recommendations for replacing the sustainable growth rate system that is used to determine the physician payment update. Unfortunately, Congress failed to act on the bill before adjourning on December 20, despite endorsements from a majority in both chambers.

For additional information on 2002 Medicare payments and the sustainable growth rate system, see "What surgeons should know about the 2002 Medicare fee schedule" on page 8.

Regulatory relief bill passes House

By a unanimous vote, the House of Representatives passed legislation on December 4 that, if also passed by the Senate, would grant significant regulatory relief to physicians. The Medicare Regulatory and Contracting Reform Act of 2002, H.R. 3391, would provide important protections to physicians who are audited. It also would streamline the regulatory process by requiring proposed or final regulations to be published on one specific business day a month and a regular timeline to be set by the Secretary of the Department of Health and Human Services for the publication of final regulations. The legislation also would prohibit retroactive applications of substantive regulatory changes. Also of interest, the Centers for Medicare & Medicaid (CMS) would be required to develop a new advanced beneficiary notice process that would allow both beneficiaries and providers to obtain predetermination of coverage before a service is delivered.

In addition to these and other regulatory reforms, the broad bill addresses Medicare contractor reforms, education and outreach programs, appeals and recovery processes, and other issues.

On November 28, Sen. John Kerry (D-MA) introduced S. 1738, the Medicare Appeals, Regulatory, and Contracting Improvement Act of 2001. The legislation, which is not as sweeping in scope as the House bill, already has the support of 21 co-sponsors, including Sens. Max Baucus (D-MT) and Charles Grassley (R-IA), the chair and ranking member of the Senate Finance Committee, respectively. At press time, the Senate had not yet acted on this legislation.

House votes to delay compliance deadline

Also on December 4, the House unanimously approved H.R. 3323, legislation that would delay for one year the October 2002 compliance deadline for standard electronic formats for exchanging health data. The bill was introduced in response to concerns expressed by state legislators and others that health care providers, payors, and clearing-

houses do not have enough time to comply with the current law's deadlines. Similar legislation, S. 1684, passed the Senate on November 27. The House bill, however, differs in that it requires covered entities seeking an extension to submit their plan for achieving compliance before the current October 16 deadline. Differences between the two bills must be reconciled by a conference committee.

CMS sets forth plans to improve

The CMS, on November 2, issued a request for comments on its efforts to become more open and responsive to the needs of Medicare and Medicaid beneficiaries and to those who are involved in their care. More specifically, the agency proposes to:

- establish a series of open-listening forums across the country to hear directly from constituents about the impact that regulations and policies are having on them;
- work closely with state and regional officials to troubleshoot and resolve disputes involving Medicaid and the State Children's Health Insurance Program;
- form in-house expert teams across program areas to develop ways to reduce administrative burdens and simplify policies and regulations;
- issue quarterly provider updates that list regulatory documents and program instructions of interest;
- enhance provider training systems; and
- reduce correspondence response time.

Some elements of the plan are now being implemented. Most notably, several open-listening forums have already been held.

Final rule issued on hospital outpatient PPS

Final regulations setting policies and rates for the Medicare outpatient prospective payment system (PPS) in 2002 were issued on November 30 by CMS. Most significantly, the rule reduces so-called pass-through payments for new medical devices, drugs, and biologicals by 68.9 percent in order to meet a congressionally mandated spending limit. As a result, payments for a number of oncology drugs and biologicals will be significantly reduced.

The new technology pass-through was created by Congress when the new outpatient payment system was first proposed in 1997, because of fears that inadequate data on these innovative products would lead to underpayment for outpatient services. To constrain spending growth, however, the total amount of such payments was capped at 2.5 percent of total PPS payments. The pass-through rate reduction for 2002 reflects recent significant increases in payment for new technology since the PPS was implemented on August 1, 2000.

Concerns about the impact these reductions could have on patient access to these technological innovations caused CMS to issue a notice on December 31 delaying the effective date of the new rates until no later than April 1, 2002. Revised rates and an effective date will be announced in a new final rule. Other provisions of the November 30 rule took effect as scheduled on January 1.

What surgeons should know about . . .

The 2002 Medicare fee schedule

by Cynthia A. Brown, Director, Division of Advocacy and Health Policy

As required by law, the Centers for Medicare & Medicaid Services (CMS) published final regulations concerning the 2002 Medicare Fee Schedule on November 1, 2001. Because the new rule followed two proposals that were issued over the summer, much of its content was anticipated. Nevertheless, the regulation contains both good and bad news relevant to surgeons. For example, the regulation finalizes changes in relative value units (RVUs) assigned to the physician work component of many services listed in the fee schedule following the completion of the five-year review. These new work values were developed after a lengthy process and, for many surgical services, are considerably higher than those that were effective in 2001. On the other hand, suspicions raised more recently were confirmed when the regulation announced a significant reduction in the fee schedule conversion factor.

Following are answers to questions surgeons may have about the new regulation and its impact on Medicare payments and policies in 2002.

Q. What is the fee schedule conversion factor for 2002?

A. The conversion factor that is used to translate fee schedule RVUs into payments was reduced by 5.4 percent for 2002, to \$36.20 (down from \$38.26 last year).

Q. Because practice costs keep increasing, it is clear that this change in the conversion factor is not intended to keep Medicare payments in line with inflation. How was the new figure calculated?

A. The fee schedule conversion factor is revised annually according to a complex formula established by law. The conversion factor is affected by the annual update as well as further adjustments to reflect other changes in law or policy. For the 2002 update of -5.4 percent, the following percentages were applied:

Medicare Economic Index (MEI)	2.6%
SGR adjustment	-7.0
BBRA adjustment	-0.2
Practice expense transition adjustment	-0.18
Five-year review adjustment	-0.46

The percentages listed do not total -5.4 precisely because the update formula is multiplicative rather than additive. In other words, the 2.6 percent MEI is recorded in the formula as 1.026, and it is multiplied by an SGR adjustment of 0.930 (corresponding to the -7.0 percentage figure).

Q. The sustainable growth rate (SGR) adjustment obviously had the greatest impact on the fee schedule update. What is it, why is it there, and how is it calculated?

A. The SGR is a prospectively determined expenditure target that is intended to restrain the growth in Medicare spending for physician services. It encompasses a variety of factors, but most importantly, it ties physician payments directly to the health of the nation's economy. In prosperous times, when the gross domestic product (GDP) growth rate is high, the expenditure target also is set high. Then, if aggregate spending remains below the target, a corresponding SGR "bonus" adjustment is made to the MEI

(Medicare's inflation rate) the following year. This past year, however, a sluggish economy was accompanied by relatively high rates of spending growth for physician and other Medicare Part B health care services. Consequently, a negative SGR adjustment was applied. (Indeed, the -7.0% adjustment is the maximum reduction allowed by law.)

Of course, relying on overall economic factors to determine the appropriate amount to spend on health care for the elderly makes little sense. Unfortunately, reliance on such an artificial "affordability factor" is only one of several serious problems with the SGR.

For example, the prospective nature of the spending target requires CMS to make predictions about factors such as economic growth and Medicare fee-for-service enrollment. Yet, when actual growth numbers become available, the agency is not allowed to recalculate the SGR standard to reflect those data prior to making the comparison with actual physician spending growth—a comparison that ultimately determines the SGR adjustment factor.

This problem was illustrated in 1998 and 1999, when agency underestimates of GDP growth, compounded by overestimates of shifting Medicare enrollment from traditional fee-for-service to managed care plans, resulted in inappropriately low SGR estimates for both years. The subsequent fee schedule updates were above the MEI but would have been even higher if CMS could have gone back and used real data before comparing actual spending growth to the target. Furthermore, the SGR system is cumulative—meaning that both targets and spending growth are calculated by taking into account spending during the preceding year, the current year, and the coming year. So, excessive spending in a preceding year and a current year have an influence on updates granted in future years. Of particular interest, if the SGRs in 1998 and 1999 could have been modified to reflect actual rates of economic and fee-for-service

enrollment growth, this difference would have more than compensated for this year's imbalance and the 2002 conversion factor update would likely have been a positive number close to the MEI.

Finally, the SGR system does not account for the introduction of costly new technologies or drug therapies that can drive Medicare spending increases.

Q. Why were the other adjustments made to the conversion factor?

A. In addition to the SGR adjustment (reduction) applied to the MEI, the conversion factor update reflects the following:

- A -0.2 percent adjustment that, according to the 1999 Balanced Budget Refinement Act (BBRA), must be applied every year from 2001 through 2004 in order to finance technical changes in the SGR law that was intended to reduce the potential for wide annual fluctuations in the conversion factor.
- A -0.18 percent adjustment to account for increased volume and intensity of services that CMS actuaries expect to occur because of changes in practice expense RVUs in 2002.
- A -0.46 percent budget neutrality adjustment to ensure that changes in work RVUs resulting from the five-year review do not cause a net increase in Medicare physician spending.

Q. What is happening to the practice expense RVUs in 2002?

A. This will be the last year of the four-year transition to resource-based practice expense RVUs. From this point on, further changes made to the practice expense component should arise primarily as the result of refinement efforts conducted by the Practice Expense Advisory Committee (PEAC) of the American Medical Association/Specialty Society Relative Value Scale

Update Committee (RUC). For 2002, CMS received recommendations from the PEAC on refinements for cost data for over 1,100 physician services, most of which were accepted. These services fall principally within the scope of orthopaedic surgery, dermatology, pathology, physical medicine, and ophthalmology.

For 2003, there may be some adjustment to practice expense RVUs assigned to the postoperative period of global surgical services to reflect refinements made in 2001 to the price inputs used to calculate practice costs for evaluation and management services. Those changes, if they do occur, will be subject to public comment when a proposed rule on next year's fee schedule is issued in the summer.

Q. In the fall, predictions indicated that the five-year review would result in good news for many surgical specialties, including general surgery. Did the final rule make this prediction come true?

A. Yes. CMS did change the physician work RVUs for several hundred surgical services as a result of the five-year review. Absent the reduction made in the conversion factor, significant gains were made by general, vascular, and thoracic surgery, in particular.

For some services, the work RVU changes were large enough to offset the conversion factor reduction. For the rest, surgeons should realize some financial gain from other public and private payors who base their payments on Medicare fee schedule RVUs. The table on this page illustrates the combined impact of the five-year review and conversion factor fee schedule changes on the national average payment for a sample service, inguinal hernia repair.

Q. This past summer, there was some confusion about CMS's plans to

Medicare payment changes for CPT 49505, inguinal hernia repair

	2001	2002	Change
Work RVUs	6.49	7.60	17.1%
Practice expense RVUs (facility)	4.02	4.13	2.7
Malpractice RVUs	0.65	0.65	0
Total RVUs	11.16	12.38	10.9
Conversion factor	\$38.26	\$36.20	-5.4
National average payment	\$426.98	\$448.16	5.0

change Medicare's payment policies for critical care services. Were any such policy changes made for 2002?

A. No. Medicare's critical care payment policies remain unchanged. That is, Medicare will continue to pay separately for critical care services that are supported by the required documentation. Surgeons may bill separately for critical care services during a global service period only when those services are unrelated to the operation, or for patients who have suffered trauma or burns. CMS will review comments submitted and determine whether to propose changes in global surgical service payments or Medicare critical care payment policies for 2003.

Q. CMS also asked questions about the -62 modifier that is used to report co-surgery. Were any decisions on this subject announced in the final rule?

A. No. Most groups and individuals commenting on the co-surgery issues raised by CMS stated that current payment policy is reasonable and that the agency should focus on education efforts to ensure appropriate use of the modifier. CMS intends to review the comments carefully and propose any changes as part of a future rulemaking process.

Q. Were any new payment policies implemented for 2002 that affect screening mammography?

A. Medicare has paid for screening mammography since 1991. However, the law governing these services required use of a payment methodology other than the physician fee schedule. Under that law, mammography screening payment equaled the *lesser* of: (1) the actual charge for the service; (2) the physician fee schedule amount for a bilateral diagnostic mammogram; or (3) \$55.00 (a 1991 figure updated annually by the MEI). That law was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and, starting in 2002, Medicare will pay for these services under the physician fee schedule at a rate of about \$88.50 (before the application of any geographic adjustments).

In addition, CMS created a temporary “G-code” (G0236) and RVUs to reflect recent FDA approval of computer-aided detection used in conjunction with diagnostic mammography.

Q. What other changes did BIPA make to Medicare screening service payment policies?

A. BIPA provided for the following screening services of interest to surgeons, each of which was addressed in the final rule:

- Low-risk women who do not qualify for annual coverage of a screening pelvic examination

that includes a clinical breast examination are now covered for services received every two (as opposed to three) years.

- Glaucoma screening services are now covered for individuals with diabetes or family history of glaucoma and for others determined to be at “high risk” for the disease.

- BIPA amended the law governing *screening colonoscopy* to extend coverage of the procedures once every 10 years for individuals not at high risk for colorectal cancer. The final rule amends regulations to conform to policies that already have been implemented through carrier manual provisions.

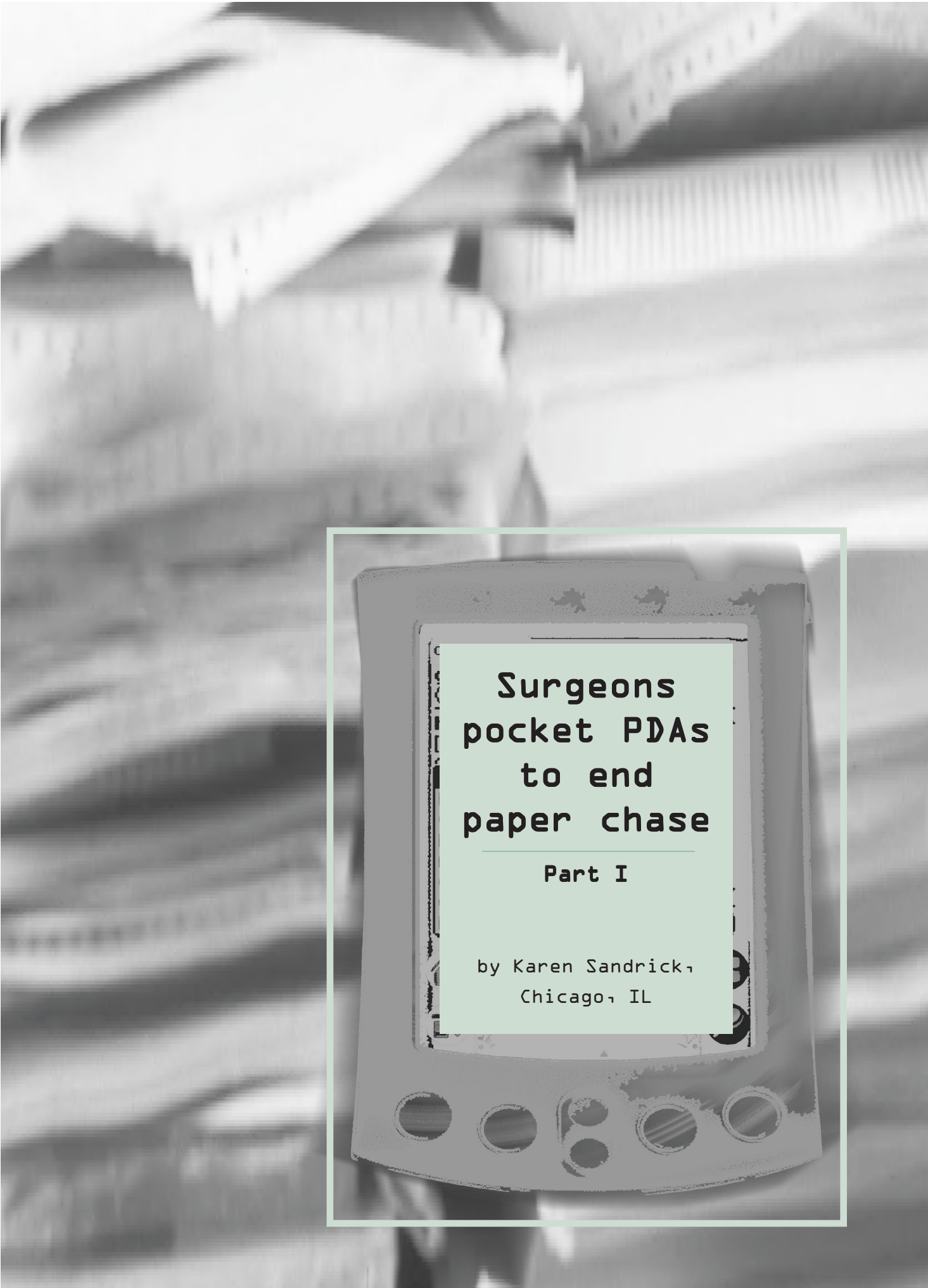
Q. Many important issues were raised this year that involve Medicare payment for surgical services. What role did the College play in these developments?

A. For the past five years, the College’s General Surgery Coding and Reimbursement Committee has worked diligently on an exhaustive review of the RVUs assigned to general surgery services. Using a new methodology, these efforts resulted in the development of new work values that were ultimately accepted by CMS at the conclusion of the five-year review. The vast majority of these services received RVU increases.

The College also led coalition efforts to develop consensus among the specialty societies and provide coordinated input to CMS on the critical care and co-surgery issues.

Finally, College staff and Fellows who responded to legislative alerts have been actively engaged in an effort to persuade Congress to intervene and legislate an increase in the 2002 conversion factor. A bill to accomplish this, S. 1707, was introduced in November by Sens. Jim Jeffords (I-VT) and John Breaux (D-LA), key members of the Senate Finance Committee. H.R.

continued on page 47



Surgeons pocket PDAs to end paper chase

Part I

by Karen Sandrick,
Chicago, IL

Until four years ago, Robert Tuchler, MD, FACS, was awash in paper. On the go from early morning to late evening—from the operating room to the office, continuing medical education (CME) session to staff meeting—the Denver, CO, plastic surgeon had no choice but to lug around a cumbersome daily planner stuffed with business cards and Post-It® Notes etched with hastily scribbled patient and referring physician phone numbers. He would rifle through pockets bulging with loose-leaf slips that chronicled appointments, to-do tasks, personal reminders, and piles of CME credit forms and crumpled expense receipts. Worst of all, because he couldn't very well cart around the latest edition of surgical texts and journals or the *Physician's Desk Reference*, he had no access to the most up-to-date diagnostic and therapeutic information or to a quick-and-easy guide to resolving complicated or unusual clinical presentations at the bedside.

All that changed when Dr. Tuchler purchased a personal data assistant (PDA). Not only does the hand-held computer simplify tracking of often maddening administrative details—his full surgical schedule and office appointments, personal and professional phone numbers, and patients' insurance eligibility information—but the PDA regularly compiles, stores, and downloads Dr. Tuchler's CME credits.

On the clinical side, the PDA contains notes on dealing with emergencies, such as antidotes to poisoning injuries, an electronic dermatome chart that explains how to treat uncommon conditions such as certain types of spider bites, and complete guides to medications, antibiotics, and infectious diseases. "There's nothing, information-wise, that you couldn't get from a library. But when you're in the recovery room writing postop orders or in the ER in the middle of the night or get a phone call from a patient at 4:00 in the morning and you can't run for your books, it's nice to be able to hit a button and have the answer at your fingertips," Dr. Tuchler said.

A small but growing number of surgeons are adopting hand-held wireless technology, and they're finding it to be indispensable. Even if Dr. Tuchler is running out to a mall in a pair of shorts, he slips his PDA in a back pocket. "I can't tell you how many times I've gotten an emergency call or

had to call a patient and needed a particular fact or a phone number," he said.

Not surprisingly, surgeons most commonly use the devices for simple clerical tasks—serving as an address and appointment book, personal and professional calendar, expense and CME tracker. But surgeons are beginning to perform more sophisticated functions—compiling searchable patient profiles and capturing charge and encounter data at the point of care.

Surgeons also are finding many clinical applications for their PDAs. Sidney F. Miller, MD, FACS, a general surgeon from Dayton, OH, connects a digital camera to his hand-held computer to monitor patients' progress after burn injuries. Barklie Zimmerman, MD, FACS, a vascular surgeon from Richmond, VA, maintains a database on aneurysms. David Lowry, MD, a neurosurgeon from Grand Rapids, MI, enters postop orders and notes in the recovery room. Roger Simpson, MD, FACS, a plastic surgeon in Garden City, NY, checks for potential drug interactions, the mechanism of action of new medications, and the appropriate antibiotic to counteract specific infectious diseases.

And surgeons are learning that PDAs are more than convenient alternatives to paper for recording and saving information. The devices improve the accuracy of diagnosis and billing, enhance the flow of information between physician and office staff, and speed access to patient-specific data as well as clinical practice guidelines and therapeutic templates.

This article reviews the administrative applications of PDAs. Next month, Part II will discuss surgical software for hand-held computers.

Gathering patient data

The charge capture and coding system for the department of surgery at Duke University Medical Center, Durham, NC, has been inefficient and incomplete for years. Because it centered on desktop computers, surgeons had to wait until they gained access to one of the department's workstations to record patient interactions. Unless they could round up all their scattered notes, by the time they sat down in front of a terminal, surgeons often would forget to include all the relevant documentation details to support specific charge codes and to meet Medicare fraud and abuse compliance requirements. As a result, according to Lloyd Hey,

MD, assistant professor of orthopaedic surgery at the Duke University Health System Spine Center, about 18 percent of all charge sheets had to be returned to surgeons' offices because an essential item of information was missing. Surgeons at Duke also often overlooked individual patient visits or interactions, which reduced their payment rates.

Since the department began instituting a PDA-based charge capture system six years ago, it has seen improvement in overall data collection. The average number of diagnoses identified by surgeons increased from 1.1 to 2.8 per patient encounter, and the fax-back rate has dropped to zero, Dr. Hey said.

The system also is helping to streamline inpatient admissions by generating a daily rounding list of patients for every surgeon that indicates where inpatients are located and when they are nearly ready for discharge. "By being able to identify a pending discharge, our system shows that a bed will be available in day or so, and that allows better planning and utilization of resources," said Robert Anderson, MD, FACS, chair of the department of surgery.

The PDA charge capture software makes it possible for surgeons to enter billing data whenever they have a few spare minutes. Dr. Hey's experience is typical: "When I arrive in the morning, I download my rounding list into my PDA and then start doing my inpatient rounds. As I see each patient, I can actually put in what was wrong with the patient and what I did about it right there at the bedside. When I go to the OR or the ER, I can do the same thing. At the end of the day, I can synchronize my PDA with the main computer, and I don't have to be at the hospital; I can do that at home. And all the patient encounters that I had that day flow electronically from my PDA through the computer, to the server, and on to the billing service," he said.

The end result is reassurance, said Dr. Hey, who developed the MDeverywhere™ charge capture system that is being used at Duke and other medical centers, such as Brigham and Women's Hospital in Boston, MA, and small group practices. "During my day, I have 100 percent confidence that I'm seeing 100 percent of the patients I'm supposed to see. At the end of the day, I know that 100 percent of my cases were captured accurately.

As life gets more hectic and my practice grows, the hand-held gives me a sense of confidence because it acts as my assistant as I'm seeing patients."

A byproduct is greater efficiency in the department of surgery and in individual physicians' practices. Because encounter data are captured by the surgeon immediately at the point of care, they are more accurate and complete, eliminating the need for office staff to rework claims. The data also are transferred directly from the PDA to the office computer by placing the device in a cradle, a process known as "hot synching," so office staff can stop wasting precious time chasing down bits of paper that were incompletely filled out in the first place. To cite one example, Duke's department of ophthalmology shaved its time to billing from 13 days to one.

In the office setting

Only a small percentage of physicians are using PDAs for charge capture and other types of transactions in their practices, such as dictating progress notes or operative reports, writing prescriptions, and accessing laboratory results. According to an analysis of the hand-held market by the San Francisco-based investment firm WR Hambrecht & Co., only 15 percent of physicians were using PDAs at the end of 2000, primarily for scheduling purposes. But Hambrecht anticipates that up to 20 percent of physicians will be turning to PDAs for transactions within three years.

And convenience will not be the only driving force; cost also will be a factor. Wireless local area networks for acquiring data at the point of care can run \$25,000 or more. PDA hardware and software are under \$1,000. So it's only a matter of time, say PDA advocates, until the devices will prove they're up to the task of handling all the data physicians' offices need to process, departmental and office information systems get the kinks out of PDA-based systems, and surgeons become accustomed to using PDAs for billing and other complicated office operations.

Meanwhile, surgeons most likely will follow the lead of early adopters of hand-held technology, such as Dr. Miller, and turn in their appointment books for a PDA.

Until Dr. Miller bought his hand-held device, he was no different than any other busy general sur-

PDA's: How do they stack up?

According to *pdasurgery.com*, the choice of a PDA depends on its cost, memory capacity, and size. The Web site provides a side-by-side comparison of the most common hand-held computers that use the Palm OS. The following is excerpted from that comparison.

Device	Price	Memory
Palm™ m100 series	\$149 - \$199	2 or 8 megabyte
Palm III series	\$149-\$449	2, 4, or 8 megabyte
Palm VII series	\$349-499	2 or 8 megabyte
Palm V series	\$329-\$399	2 or 8 megabyte
Visor™	\$179	2 megabyte
Visor Deluxe	\$249	8 megabyte, expansion
TRGPro™	\$329.99	8 megabyte
Sony Clie™	\$349	8 megabyte, expansion
IBM Workpad c3	\$384.99	8 megabyte

Smaller and thinner PDAs include the Palm Vx, Palm M 505, Sony Clie, and IBM Workpad.

In addition to the systems that run on a Palm OS, the Hewlett Packard Jornada and Compaq iPAQ Pocket PC synchronize with Windows® and Microsoft Outlook, Word, and Excel. The Compaq iPAQ has 32 to 64 megabytes of RAM and 16 megabytes of ROM and runs around \$500; the HP Jornada model 545, which has 16 megabytes of memory, is about \$850, and the 548 model, with 32 megabytes of memory, is more than \$1,000.

geon: in a constant paper chase with office staff to make sure everyone was on the same calendar page with the most up-to-date appointments, addresses, and phone numbers. But now, instead of shuffling bits of paper back and forth, and hoping they don't get lost or misplaced somewhere along the way, all he has to do is hot sync his hand-held device with his computer, and he and his secretary can make instant changes to his schedule.

And like Dr. Miller, surgeons also may start experimenting with other uses of hand-held computers. For the last few years, for example, Dr. Miller has been taking his PDA on trips to medical meetings along with a keyboard that collapses to the

size of his palm. As a result, when the lights come up after a formal paper presentation, Dr. Miller can pull out his PDA, open the keyboard to standard size, and type in notes about the talk. He also can enter travel expenses directly into the device. Once he's back at the office, he can sync the device with the computer, which copies expenditures onto an Excel worksheet for tracking and completing travel requisitions.

Surgical residents can find even more applications for the devices: tracking the cases they perform for the American Board of Surgery, to name one. "The American Board of Surgery has made available an option to collect this information on a hand-held device. So residents, right after they leave the OR, can go into the surgery lounge, pick up their hand-held device, and type in the patient's name, the operation, the date, the attending surgeon's name, and their participation in the operative procedure—all in about 30 seconds. Then once a week or every month, they can come over to the department office and give their hand-held device to the secretary, who syncs it with the computer and downloads all the information," said Dr. Miller, professor of surgery at Wright State University and director of the Miami Valley Hospital Regional Adult Burn Center, both in Dayton, OH.

The process also gives the department of surgery at State University of Dayton much more complete data, much more promptly, he added. "We used to have to call up the residents and bug them, and they were still about two months behind. And they were always trying to piece things together because they forgot to write down their operative cases as soon as they came out of the OR. Now they carry the hand-held device in their shirt pocket and pack all that information in this thing that's just a little bit bigger than a pack of cigarettes."

Getting started

Every hand-held computer comes with a suite of applications, or a skeleton, as Dr. Tuchler calls it, that will meet almost any surgeons' clerical needs: an appointment scheduler, phone directory, to-do list, and the ability to type short memos. There are dozens of Web sites that offer software, free of charge or for purchase, exclusively for physicians to expand PDA applications. In addition

continued on page 55

9/11

Another reason to “ungate” health care

by Lawrence A. Danto, MD, FACS, Stockton, CA

The recent tragedies in New York City, Pennsylvania, and Washington, DC, still overshadow and preoccupy most aspects of American life. This is particularly the case with regard to the health care industry and efforts to reform it. Participants at the September 2001 State of the State of Health Care Forum in Massachusetts were warned that not only has Congress set aside prescription drug and patient rights initiatives, but mounting job losses and dwindling government revenues threaten access to health care across America more than ever. Said Thomas A. Scully, Administrator of the U.S. Centers for Medicare & Medicaid Services, “National defense is going to take priority over everything.”

While it is important to focus on an appropriate response to terrorism, we must also protect ourselves and get on with our lives—securing a free

and stable future. Not only do we owe it to those who sacrificed their lives, but, even more, we owe it to the survivors—to ourselves. If we don’t move on, we will end up losing this global war to the terrorists.

Lessons of history

Interestingly, there is a strong historic association between world war and changes in the socioeconomic structure of health care delivery. Before World War II, health care delivery was based on a simple, fee-for-service system. If patients could afford care, they received it; if they couldn’t afford treatment, for the most part, they didn’t receive it. The notion of selling health insurance was unborn.

During WWII, all industrialized nations (except the U.S.) either suffered mainland attack or were

in constant fear of the very real prospect of injured civilians from such an attack. It became immediately apparent that private economic concerns should not affect the emergency triage of domestic casualties. The global response was to create national emergency health care systems whereby the national government economically, administratively, and physically supported emergency health care.

As peace settled back in place, these same nations, in response to the postwar economic recession, high rates of unemployment, and the continued need to provide basic health care services, transformed their wartime emergency health care systems into national programs that could deliver basic care to all citizens at all times. These countries recognized that a modern national workforce depends on effective access to basic health care.

On the other hand, the U.S., protected by two vast oceans, was free from the threat of mainland attack during WWII. The arsenal of democracy emerged from that global conflict with a surging economy and near universal employment. Our response to funding health care was to continue the prewar fee-for-service system and to support it with the employment-based system of privately funded health insurance that had been developed during the war and used to attract scarce workers into wartime employment. This system functioned beautifully during the two postwar decades in which the U.S. economy was booming and supporting the world economy as well. Further, it made some sense when most workers expected a lifetime of employment by one firm. However, as the industrialized world recovered, we began to lose our economic advantage and, at present, our average job tenure is three to five years—physicians included.

The rest of our economic history is easy to recall—continued and unavoidable global health care inflation. Our knee-jerk response has been to set arbitrary limits on health care spending by allowing managed care, capitation, and gatekeeping to become the watchwords and primary focus of the health care industry. However, the cost of care has continued to rise as it must in any free, technocratic society with an aging population. Sadly, there are now restrictions on essential services even for those of us who are employed and well-insured. The vast majority of Americans

now have access to care only with the approval of a gatekeeper.

Even so, HMOs, unable to squeeze any more profit out of the system, are losing money and only the largest and most aggressive are able to stay in business. Private managed care is in a definite state of decline and this administrative experiment has caused the health status of the U.S. citizenry to decline from first to last place among the major industrialized nations, according to the *2001 World Health Report* of the World Health Organization.

Emergency room crisis

An even more critical issue is the closure of numerous emergency rooms throughout the nation. As Frank Staggars, Jr., MD, president of the California Medical Association, recently said, “We dearly need to preserve our emergency [health care] system so it will be available when we need it.” True enough, but the problem is more complex than it first appears.

Many ER closures have occurred because, for various reasons, institutions have failed to provide adequate staffing and technical support for the emergency rooms they provide. As any surgeon knows, it is dangerous, unethical, and even illegal to hang an ER sign on the side of a hospital unless the institution is truly capable of providing the level of care it is advertising. These so-called ERs, quite frankly, need to be closed.

On the other hand, there are millions of uninsured and underfunded patients who are afraid to go to the doctor or to the ER until it’s too late. There are millions more insured and well-funded patients who have to call their gatekeeper before going to the doctor or ER. The dangerous fact is that our financial mindset often slams the gate to lifesaving care, and the portal often stays closed until it’s too late.

The sentinel example of this tragedy is the unfortunate postal worker who, suspecting he had contracted inhalation anthrax, instead of simply going to the emergency room, went to “his doctor.” His doctor happened to be employed by the largest and oldest private HMO in the country. Without an appropriate workup, he was told he probably had a virus and to treat himself symptomatically.

In effect, this person ended up being denied ac-

cess to care by someone at least perceived as a gatekeeper. Only after his illness worsened at home did he call 911 to ask what he should do, but by then it was too late. Think of this astounding reality: Our patients are now so conditioned by decades of gatekeeping from employment-based managed care that, even when faced with death, they first ask permission before seeking care.

The tragic events of September 11 are bringing the eye of public concern to focus on the longstanding inadequacies in our system of health care. Because our government is the only entity capable of responding to terrorism, it is the only one that can mend the gaping holes in our health care safety net.

Surviving a 360-degree war

For the first time since the Civil War, parts of mainland America have been attacked and devastated by an act of war. For the first time, we know how the rest of the world has been living—with the terrible reality of continual civilian casualties. Our protective oceans have finally been bridged, and the course of U.S. history has been wrenched in an unexpected direction. For the first time, we are at war on all fronts—a “360-degree war.”

Like December 7, 1941, and November 22, 1963, the attacks last fall will be forever recognized by the date on which they occurred—the simple, stark designation of 9/11, the universal emergency number. The loss of life was enormous, as was the threat of seriously injured victims. It has already become apparent that because of our restrictive health care system, survivors of domestic terrorism face medical expenses and lost wages while they recover.

In truth, we are all survivors of 9/11, and we are threatened by its legacy. Further, in the foreseeable future it is likely that all of us will face medical expenses and lost wages while we struggle to live on in the shadow of the horrific events of that fateful Tuesday. Arguably the major socioeconomic lesson is that our private system of managed care instantly failed to meet the needs of this new crisis. The major lesson in government studies is that an ungated and universal system of health care delivery is integral to national defense.

The prospect of an American national emergency health care system has now become a significant part of the societal dust rising from the

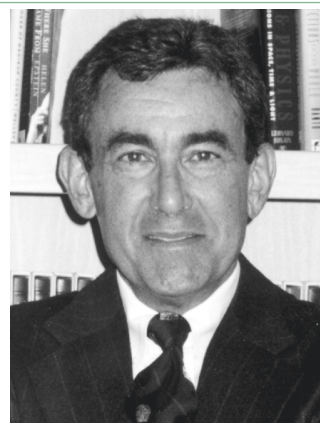
rudder at ground zero—the ruins of the World Trade Center. The prospect of large numbers of civilian casualties, not just from physical trauma but from chemical and biological warfare as well, has created a new impetus for a health care reform, and Congress must respond. Emergency care is not a second-priority issue.

Questions such as these remain to be answered: Can we allow emergency rooms to close because not enough patients have access to them? In a time of national crisis, can we afford to have our gate to emergency health care controlled by private concerns? Can we allow private enterprise to significantly affect the emergency triage of our domestic casualties?

The rest of the industrialized world responded more than 50 years ago during WWII. However, in our terrorized and no-longer isolated U.S., employment-based managed care has become a real threat to our security, and the previous questions continue to cry out for answers. Stated in more blunt terms, in twenty-first century terrorized America, in a time of national emergency, can we possibly let private gatekeepers deny care to our injured loved ones?

The nature of surgery is the nature of emergency health care and dealing with disasters. As surgeons we should push especially hard to establish universal access to emergency care, and make an ungated health system the reality for us all. **Q**

Dr. Danto is a general surgeon at San Joaquin General Hospital, Stockton, CA, and clinical professor of surgery, University of California, Davis.



This article presents some of the changes in *Current Procedural Terminology 2002* (CPT). Modifications such as the new features of CPT, the definition of the global surgical package, instructions for the use of CPT, and revisions to modifiers will interest all surgeons and their billing staffs. The remainder of the article will probably be of interest only to general surgeons, closely related specialties, and their billing staffs.

New features of CPT

In August 2000, CPT was selected as the procedure coding system for physician and hospital outpatient services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). An elaborate assessment was done of CPT prior to that time to ensure that CPT met the needs of many users. Physicians, nonphysician health care providers, researchers, managed care plans, hospitals, and other institutional providers all were consulted to determine what changes they would make to CPT. The result was the development of a number of improvements in CPT, which helped to ensure that it would be selected as the coding system for physician services under HIPAA. The early changes are appearing in 2002, with more changes to be reflected in future editions of *CPT*.

For 2002, CPT established 25 codes in a new category called emerging technology. The codes in this category do not have to

All specific references to CPT terminology and phraseology are: CPT only © 2001 CPT American Medical Association. All rights reserved.

CPT changes in 2002

•

by

John T. Preskitt, MD, FACS,

and

Jean A. Harris,

Associate Director,

Division of Advocacy and Health Policy

meet the usual CPT requirements that the procedures be widely performed and that the appropriate Food and Drug Administration approvals have been received. The creation of this category of codes is an especially welcome development now that third-party payors are beginning to pay for some of the costs associated with investigational procedures. Emerging technology codes:

- Have a four-digit number followed by a "T" and are in code-number sequence. The five-digit alphanumeric number does not have any meaning beyond identifying it as an emerging technology code. Numbers are sequential as codes are assigned, so the first emerging technology code was assigned 0001T, the second was assigned 0002T, etc. Therefore, codes will not be logically ordered according to the type of services they represent, and if closely related codes are approved at different times, they will not appear together.
- Must be reported instead of unlisted procedure codes that end in 99. Cross-references will be placed in the traditional part of CPT to facilitate proper reporting.
- Do not have a relative value assigned for Medicare, although certainly a private payor may choose to pay for the code. For Medicare, no payment will be made for codes that have a national noncoverage determination; coverage and payment will be at the discretion of local carriers for the rest of the codes.
- Can be moved into the main part of CPT at any time as long as they meet the criteria for traditional codes.
- "Sunset" after five years. There are a very large number of editorial changes in CPT 2002. Editorial revision will continue in 2003 because efforts are being made to systematically change certain aspects of CPT's structure. These changes are in addition to editorial changes made to individual codes to clarify them or because new codes have been added. Of course, none of these editorial changes will result in the assignment of new relative values.

One large group of editorial changes was made to standardize the terminology throughout CPT. In the past, for example, the term "allograft" has been used in some descriptors, and the term "homograft" has been used in other descriptors. Now only the term "allograft" will be used. The list of terms is quite extensive, with some terms seman-

tically very close ("dilation" and "dilatation") and some terms far apart ("Hirschsprung disease" and "congenital megacolon"). Only the approved terms will be used in the future.

The CPT editorial panel did not select the "winning" term. Instead, CPT was run against the *Metathesaurus* of the National Library of Medicine to identify synonyms. Primary factors in the selection of terms by the CPT editorial panel were the preferred terms of the *Metathesaurus* and the predominant physician usage. The same process is being used for other applications, such as electronic medical records; thus, CPT's inclusion of *Metathesaurus* terms will facilitate the merging of CPT into computerized medical record systems.

Another large group of editorial changes has been made to substitute concrete terms for the phrases "any method," "any approach," or "any technique." For example, in the codes 17000-17286 for destruction of skin lesions, the phrase "any method" has been replaced by "e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement." Much the same was done with "any approach" in that the approaches are now named, and for "any techniques" as some or all of the techniques are now named.

There also has been a change in the way the CPT editorial panel conducts business, with more changes planned in the future. The meetings of the editorial panel are now open to physicians who serve on the CPT Advisory Committee, the AMA/Specialty Society RVS Update Committee (RUC) and the RUC Advisory Committee, and the Practice Expense Advisory Committee (PEAC), and the staff of those committee members. Proposals for CPT changes are most often submitted by specialty societies and presented to the panel by representatives from those societies. When proposals are made by other individuals or groups, the author of the proposal is invited to attend and participate in the portion of the panel meeting that deals with the proposal.

This new process enlarges the role of the specialty societies in the editorial process and makes it more important that they have a representative present when codes of interest are being discussed. A very practical outcome has been that the specialty society representatives have an opportunity to point out problems they see in an action

that the panel is about to take. This capability will be especially helpful when the panel chooses to modify the coding proposals.

Definition of the global surgical package

The CPT definition of the global surgical package has been expanded considerably to specify additional services that are widely recognized as part of the surgical package (see box, right). We believe that it will help bring about greater standardization of the global surgical package. Significant additions include:

- One related evaluation and management (E/M) encounter on the day prior to or on the day of surgery. Note that this is not the visit when the decision to have surgery is made. The decision for surgery E/M encounter is still separately billable with the appropriate modifier. For major procedures, the modifier is -57 (Decision for surgery), and for minor procedures it is modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

- “Typical” postoperative care. Because the basic surgical package definition now states that it includes typical postoperative care, any unusual treatment may be reported using the -24 modifier. The language with respect to follow-up care for therapeutic procedures has been revised to emphasize that the treatments of atypical events such as “complications, exacerbations, recurrence, or the presence of other diseases or injuries” are separately billable with appropriate modifiers. The most frequently used modifiers are -24 (Unrelated evaluation and management service by the same physician during a postoperative period), -78 (Return to the operating room for a related procedure during the postoperative period), and -79 (Unrelated procedure or service by the same physician during the postoperative period).

Instructions for use of CPT

There has been an important modification to the instructions for use of CPT when there is no descriptor that exactly matches the procedure done. The old language indicated that the procedure that “most accurately” identifies the procedure performed should be selected. The language now reads as follows, with changes in wording in bold type here for easy identification:

CPT surgical package definition

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia.
- Subsequent to the decision for surgery, one related E/M [evaluation and management] encounter on the date immediately prior to or on the date of procedure (including history and physical).
- Immediate postoperative care, including dictating operative notes, and talking with the family and other physicians.
- Writing orders.
- Evaluating the patient in the postanesthesia recovery area.
- Typical postoperative follow-up care.

Select the name of the procedure or service **that accurately** identifies the service performed. **Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code....** Any service or procedure should be adequately documented in the medical record.

This language, of course, makes it easier to raise questions of fraud when the procedure actually performed does not match the code reported. To be more precise, a payor conducting an investigation will be judging how well the medical record matches the procedure. Of course, Medicare, Medicaid, and other government programs have been concerned about fraud for some time. HIPAA extended these same standards to private payors, so they now have the same tools to fight fraud. Be

careful about reporting a code that results in a higher payment than the procedure actually done.

This change in language doubtless will result in the addition of more codes to CPT. General surgeons wishing to pursue additional codes should contact Irene Dworakowski, Coding and Reimbursement Associate, in the College's Washington Office at idworakowski@facs.org.

Modifiers for two surgeons and altered surgical field (modifier –62)

The modifier that permits reporting of two surgeons serving as co-surgeons on a case has been changed to permit its use for the primary procedure and any associated code(s), as long as both surgeons continue to work together as primary surgeons. Previously, its use was limited to a single procedure code, meaning that often one surgeon did not get appropriate reimbursement for the work he or she did, and the codes used did not reflect the full picture of what was done. The need to report multiple codes when performing anterior spinal access procedures drove this change. Therefore, there are several places where notes have been added to the spine sections (in both the musculoskeletal surgery portion and in the neurosurgery portion) of CPT, giving specific direction regarding the new use of the modifier. A quick review of coding basics: A co-surgeon writes a separate operative note regarding his or her participation in the procedure and may play a role in the postoperative care. An assistant at surgery does none of these things.

In CPT 2001, a separate modifier, –60, was established to indicate that there was increased operative complexity or time caused by an altered surgical field. This modifier has been deleted as well as the note referring to it in the text of unusual procedural service modifier, –22. Medicare did not recognize modifier –60 and there were reports that other payors were not recognizing it either. Deletion of the modifier and reference to it means that an altered surgical field is reported using the –22 modifier.

Vascular procedures

Prior to 2002, code 35646 was used to report both aortofemoral and aortobifemoral bypass grafts performed with synthetic conduit. Code 35646 now refers only to aortobifemoral bypass

grafting and a new code, 35647, refers to aortofemoral bypass grafting.

Adjuvant techniques may be required at the time a bypass graft is created to improve the graft's patency. A new add-on code, 35685, was created for the placement of a vein patch or cuff at the distal anastomosis of a bypass graft. Another new add-on code, 35686, was developed for the creation of a distal arteriovenous fistula during lower extremity bypass surgery.

A new code, 36002, was added to describe thrombin injection for percutaneous treatment of an extremity pseudoaneurysm. This new procedure is performed most commonly for pseudoaneurysms that develop after cardiac catheterization or peripheral angiography. This injection code is designed to be reported in addition to a guidance code, and most commonly that will be 76942, Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), radiological supervision and interpretation. A note was added instructing users not to report this code when placing a vascular sealant to close an arteriotomy site at the time the angiographic catheter is removed.

A new code, 36820, for hemodialysis graft procedure by forearm vein transposition was created. Code 36819 was editorially revised by inserting "upper arm" so that it reads "Arteriovenous anastomosis, open; by upper arm basilic vein transposition."

Finally, the introductory notes to the endovascular abdominal aortic aneurysm repair codes have been revised to clarify procedures that are separately reportable.

Procedures on the intestine, rectum, and anus

Revisions also were made to create separate codes for laparoscopic small bowel resections and laparoscopic colon resections. The revisions made the open small bowel (codes 44120-44121) and laparoscopic small bowel (codes 44202-44203) similar. Code 44202 was revised to make it describe a single resection and anastomosis of the small bowel (Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis) and a new add-on code, 44203, was created for each additional resection and anastomosis. Code 44202, Laparoscopy, surgical; colectomy, partial, with

anastomosis, and code 44205, Laparoscopy, surgical; colectomy, partial, with removal of the terminal ileum with ileocolostomy were added.

Code 45136, Excision of ileoanal reservoir with ileostomy, was added to describe the excision of a previously created ileoanal reservoir. Code 46020, Placement of seton, has also been added.

Ablation of liver tumors

Codes were added to the surgery section for ablation of liver tumors and to the radiology section for guidance for the ablation of tissue. Specifically, codes were added in a newly created laparoscopy section for the liver; they are code 47370, Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency, and code 47371, Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical. Code 47380 was also added for Ablation, open, of one or more liver tumor(s); radiofrequency and code 47381 was added for Ablation, open, of one or more liver tumor(s); cryosurgical. Finally, code 47382 was added for Ablation, one or more liver tumor(s); percutaneous radiofrequency. In the radiology section, three codes were added for the computerized topographical, magnetic resonance, and ultrasonic guidance and monitoring of tissue ablation (codes 76362, 76394, and 76490, respectively).

Pediatric surgery

Two new codes were added to describe an esophagoplasty for repair of a congenital defect. Code 43313 is for Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula. Code 43314 describes the procedure with repair of a congenital tracheoesophageal fistula.

Three new codes were added for resection of the small intestine for congenital atresia. Code 44126 is for Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering. Code 44127 includes tapering and code 44128 is an add-on code for each additional resection and anastomosis.

Two codes were added for initial inguinal hernia repair on preterm infants. The codes themselves are very simple, paralleling the pair of codes already in CPT for children under the age of six

months and for children from six months to less than five years. Code 49491 is for Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconceptual age, with or without hydrocelectomy; reducible. Code 49492 is for the repair of an incarcerated or strangulated hernia in an infant of the same age.

The measurement of age is complex but is explained in notes in CPT. The infant must have been less than 37 weeks gestational age at birth and be less than 50 weeks postconceptual age at the time of the hernia repair. Postconceptual age is gestational age at birth plus the age of the infant in weeks. An editorial change was made in the existing codes so that preterm infants of less than 50 weeks postconceptual age are excluded from codes 49495 and 49496. Q

Dr. Preskitt is attending surgeon, Baylor University Medical Center, Dallas, TX. He is a Regent of the College and a member of the ACS General Surgery Coding and Reimbursement Committee.



Committee keeps College fiscally prepared for the future

by William F. Sasser, MD, FACS, *St. Louis, MO*



The Committee to Study the Fiscal Affairs of the College held its annual meeting on October 6, 2001, just prior to the Clinical Congress in New Orleans, LA. This meeting followed a special session that took place in August for the committee members at the College's headquarters in Chicago, IL. The purpose of the August meeting was to allow sufficient time for members to review and discuss the financial resources, programs, and initiatives of the College in light of the recent flurry of activity resulting from strategic planning efforts. Committee members had the opportunity to meet with the College's executive staff and to provide them with input on College programs and initiatives. We also reviewed and discussed the cost of membership services. As Secretary of the Board of Governors, I chaired both of these meetings. These sessions and the new course that has now been set for the College have made my last year as Secretary interesting, involving, and enjoyable.

Dues structure

An official responsibility of the committee is the annual review of the dues rate structure of the College. As you know, the College has kept dues at the same amount for 10 years. The purchasing power of the dollar over this 10-year period has declined, and the College has responded with cost-saving improvements and limits on the expansion of existing activities or the implementation of new programs.

The arrival of Thomas R. Russell, MD, FACS, as Executive Director signalled a new direction for the College. Dr. Russell and College leadership initiated a strategic planning process that included a detailed analysis of College resources and input from a broad cross-section of the membership. The process culminated in a strategic plan that the Board of Regents approved in June 2001.

The Committee to Study the Fiscal Affairs of the College determined a dues increase was warranted based on the cost of providing member services and of implementing proposed programs and initiatives. They also believed that a dues increase at this time would provide management with the flexibility to implement the strategic plan and would allow some of the new programs and initiatives to be launched. The dues rate structure proposed was an increase in domestic and institutional Fellows' dues of \$65, or annual dues of \$440, and an increase in

Canadian Fellows' dues of \$15, or annual dues of \$335. The committee again approved the proposed dues increase at its October 6 meeting and presented it as a recommendation to the full Board of Governors at their meeting on October 7, 2001. The Board of Governors, the Finance Committee of the Board of Regents, and the Regents as a whole approved the dues increase recommendation.

However, subsequent to the Clinical Congress, the Medicare conversion factor for physician fees for 2002 was released and included a projected payment reduction of 5.4 percent. Based on this news, Dr. Russell communicated with the Board of Regents, and a decision was made to hold dues constant for another year, the 11th in a row.

Scholarships, Fellowships, other awards

The Board of Regents approved \$1,532,000 funding for resident research scholarships, faculty fellowships, eight international guest scholarships, and the 12th Clowes Research Career Development Award. The new funding limit will become effective in 2003. The Board also approved two jointly sponsored awards. The first award, to be initiated this year, is being sponsored in conjunction with the Head and Neck Society and is a Faculty Career Development award for Oncology of the Head and Neck. The second award will be co-sponsored with the Royal College of Surgeons of England for a Research Fellowship Exchange. The awards are funded through the 2001 Annual Fund and the various endowment funds available for scholarships and fellowships, as well as a \$60,000 contribution from Ethicon, Inc.

Finance and development

The College's Comptroller, Gay Vincent, presented a detailed financial report. Highlights of her report are as follows:

- *August 31, 2001, financial statement.* For the two months ending August 31, 2001, College financial results were favorable compared with the budget. The favorable variance is the result of unfilled staff positions, savings in trauma meeting costs, and 2001 Initiate fees that were billed in fiscal 2002. At press time, the favorable variance was anticipated to hold through year-end.

The College's assets, which include operating assets, real estate, and investments, totaled \$254 million (\$272 million at August 31, 2000). Net in-

vestment activity added approximately \$172,000 to operations versus a budget of \$543,000. The decline was due to poor market performance for the two months. The market value of the investments was \$193 million (\$208 million at August 31, 2000).

- *Investments.* The Investment Subcommittee of the Finance Committee has been very busy this past year. New investment managers were selected for large cap growth and small cap value strategies. The new managers were selected to continue the diversification of the portfolio and to move out of index funds into actively managed funds. The Finance Committee and the Board of Regents approved the new appointments.

The Investment Subcommittee also approved a Joint Investment Program for the College. The program will allow other 501(c)(3) surgical organizations to invest their funds with the College. The College's endowment fund is large enough to take advantage of separately managed accounts, reduced investment fees, and diversification into alternative markets. These advantages are not available to most affiliated organizations due to the smaller size of their investment portfolios.

The preliminary estimates for net investment returns for the quarter ended September 30, 2001, were (6.6) percent, with the year-to-date (January to September) at (8.2) percent. The endowment performed well as compared with a 70 percent Standard & Poor's 500 Index/30 percent Bonds Index, which returned (16.1) percent for the year-to-date September 30, 2001.

- *Pension Plan.* The Finance Committee reviewed the annual report of the staff members' retirement plan as of December 31, 2000, and 1999. The plan is an above-market benefit for College staff and is important in recruiting and maintaining staff. In 1999, the Trustees approved lump-sum distributions. The offer of lump-sum distributions is a rich and popular benefit. The defined benefit plan had assets of \$10.9 million and accumulated plan benefits of \$9.8 million. Actuaries at William M. Mercer, Inc., perform an actuarial valuation of the plan, and the College's public accounting firm, Deloitte & Touche, audit the plan. Contributions of \$1.6 million were made to the plan during 2001. The plan's assets are supervised by the Investment Subcommittee of the Finance Committee of the Board of Regents.

The long-term savings plan is a 403(b) tax-deferred annuity plan offered to the College staff. Participation is voluntary. After one year of service, an individual's contribution is matched at the rate of 50 percent, up to a maximum College match of 3 percent of salary.

- *Insurance program.* The Finance Committee of the Board of Regents recommended a reduction in the administrative fee for the conventional and cost-advantage health plans and the disability plan. The Board of Regents approved the recommendations. The administrative cost reduction should reduce the rate of premium increases for these plans over the next few years. Due to the many activities of the insurance program, a special article was presented in the December 2001 *Bulletin* (p. 48). Please take some time to review that article.

- *Development program.* The Development Committee and staff have also been very busy. The Fiscal Affairs Committee reviewed a business plan that was subsequently approved by the Finance Committee and the Board of Regents. The business plan will provide additional resources for the Development Program, with an anticipated increase in fund raising. All Fellows of the College are very strongly encouraged to consider making a tax-deductible contribution to the Development Program to support research and education and to help maintain and expand the strong research and education programs of the College. Fred Holzrichter, the Development Program Manager, prepared a report on the Development Program. Highlights of his report were as follows:

Philanthropic cash contributions to the College totaled \$455,723 as of September 13, 2001. Twelve new Life Members (gifts or pledges of \$10,000 or more) were recorded during the year. There are now 297 members of the Fellows Leadership Society who are at the Life Member category or higher. Twenty-three chapter gifts were received (\$36,025) and nine specialty societies (\$10,000) made contributions. The largest single gift came in the form of a \$300,000, three-year commitment, from Merck & Co., Inc.

The 13th annual Fellows Leadership Society awards luncheon took place October 8, 2001. The Committee on Development recognized Pon Satitpunwaycha, MD, FACS, a general surgeon

from Houston, TX, with the 2001 Distinguished Philanthropist Award.

The Development Committee is expanding efforts to work with medical industry to secure unrestricted grant funding to support College research and education initiatives. The committee also is working to take its message regarding philanthropic opportunities directly to the Fellowship through increased exposure of funding possibilities via the presence of the Development Program exhibit at chapter meetings.

Conclusion

I have sincerely enjoyed my leadership role with the Board of Governors, and I am even more enthusiastic about the increased activities and new direction for the College that I see on the horizon. It has been a pleasure working with the committee this year, and I would like to thank Drs. Carl E. Bredenberg, John L. Cameron, Fred Allen Crawford, Jr., G. Richard Geier, Jr., Scott A. Hundahl, Larry Robert Lloyd, Edward Andrew Luce, Francis Daniels Moore, Jr., Thomas L. Raftery, William Charles Sternfeld, Gary Lee Timmerman, and Thomas Wachtel for their service on the committee. I also would like to thank College staff members Fred Holzrichter, Gay Vincent, Keith Bura, and Lynese Kelley for their excellent efforts. Special recognition is also given to Jack Lynch as he completes his many years of service and devotion to the College. Jack has left an unmistakable imprint on the activities of the Board of Governors and the College. Thank you, Jack, and best wishes for your retirement. □

Dr. Sasser is chief, division of thoracic surgery, St. John's Mercy Medical Center, St. Louis, MO, and Chair of the B/G Committee to Study the Fiscal Affairs of the College.



Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first Web-based and only continuously updated surgical reference.

XI. Surgical Techniques

25. *Laparoscopic Donor Nephrectomy*. Stephen C. Jacobs, MD, FACS, and Stephen T. Bartlett, MD, FACS. In their new chapter, the authors detail how to perform laparoscopic nephrectomy with maximal efficiency and minimal complications. Since the latter part of the 1990s, laparoscopic living donor nephrectomy has become established as the surgical approach of choice in most large renal transplant programs (including the authors' own center at the University of Maryland). It has both enlarged the pool of willing potential renal donors and increased the supply of kidneys for transplantation. Although laparoscopic harvesting is now well developed, there is probably room for further refinement. For instance, systemic vasodilation might improve intraoperative renal blood flow and enhance urine production. The extraction site, however, appears to be optimal as is. Still, the laparoscopic approach poses risks to both the do-

nor and the allograft recipient. These risks are potentially catastrophic and militate against casual embarkation of a laparoscopic donor nephrectomy program. A good case can be made for restricting laparoscopic donor nephrectomy to a few centers where a large number of cases are done. Few, if any, patients are more easily moved a substantial distance for an operation than a living renal donor.

The full text of "Laparoscopic Donor Nephrectomy" may be viewed online in the physician portion of the WebMD Web site, at www.webmd.com. Click on *ACS Surgery: Principles and Practice*.

VIII. Evaluation of Common Clinical Problems

1. *Neck Mass*. Barry J. Roseman, MD, and Orlo H. Clark, MD, FACS. Assessing patients with a neck mass offers something of a clinical challenge. The final diagnosis might include any of a number of inflammatory disorders, congenital cysts, or benign or even malignant neoplasms. Therefore, the initial evaluation requires a careful history and a thorough examination of the head and neck, which in itself is challenging because much of the area is not easily visualized. One's initial diagnostic impressions and the degree of certainty one attaches to them determine the next steps in the workup and management of the neck mass. Options include empirical therapy, ultrasonographic scanning, computed tomography, fine-needle aspiration (FNA), and observation alone. For example, in a patient with suspected bacterial lymphadenitis from an oral source, empirical antibiotic therapy with close follow-up is a reasonable approach. In a patient with a suspected parotid tumor, the best first test is a CT scan: The tumor probably must be removed, which means that one

continued on page 41

Monthly updates to the online version of *ACS Surgery: Principles and Practice* in the physician portion of the WebMD Web site, at www.webmd.com, are also available quarterly through subscription to the *ACS Surgery* CD-ROM, which incorporates every online update from the previous three months and yearly through subscription to the annual hardcover edition of *ACS Surgery: Principles and Practice*, which incorporates every online update from the preceding year. To learn more, visit the *ACS Surgery: Principles and Practice* page on the ACS Web site, at www.facs.org/members/acs_surgery.html.

Mr. Kelly is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

Internet resources for coding and reimbursement policies

To assist Fellows and their staffs in their coding efforts, we thought it would be helpful to note some of the coding and reimbursement resources that are available on the Internet.

For example, the Centers for Medicare & Medicaid Services (CMS) Web site has a specific page for providers and health plans (<http://www.hcfa.gov/audience/planprov.htm>). The site contains links to other CMS Web pages from which you can download forms, the annual Medicare fee schedule and quarterly updates, the annual updates of ICD-9-CM and HCPCS codes, and current information about various CMS initiatives.

CMS also offers several computer-based basic training programs as part of their Medicare Learning Network (<http://www.hcfa.gov/medlearn/>). This site contains links to computer-based training courses on Medicare basics, ICD-9-CM coding, and the HCFA-1500 form.

Meanwhile, most Part B carriers now have provider Web sites where coders can find copies of provider newsletters, physician fee schedules, information on coding courses offered by the carrier, and current and draft carrier local medical review policies (LMRPs). A directory of links to Web sites of most Medicare carriers and intermediaries can be found at <http://www.lmrp.net/directory.asp?Type=lmrp>. This Web site also tells the reader whether LMRPs are posted on a given Web site.

Some private payors have also instituted informational Web sites for physicians. The Blue Cross Blue Shield Association, which is the national umbrella group for most Blues plans, has a Web site that not only offers guidance on policies that it recommends to its members (<http://www.bcbs.com/healthprofessionals/index.html>), but also has a page of links to the individual member plans (<http://www.bcbs.com/healthinsurance/index.html>). Likewise, the Health Insurance Association of America has a Web site of its members where physicians may find provider information for commercial health insurers (<http://www.hiaa.org/membership/members.cfm>). And the American Association of Health Plans lists a Web

Around the corner

January

- The 90-day implementation period for the 2002 CPT and HCPCS codes, effective on January 1, continues until March 31, 2002.

February

- ACS-sponsored advanced coding workshop for surgeons at the North Texas Chapter meeting on February 21, 2002, in Dallas, TX. Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html> or contact Irene Dworakowski at 202/672-1507 or Idworakowski@facs.org to register.

page containing links to its member managed care organizations (http://www.aahp.org/Content/NavigationMenu/About_AAHP/Who_We_Are/Health_Plan_Member_Links/Health_Plan_Member_Links.htm). The Coalition for Quality Affordable Healthcare, a consortium of 26 of the largest insurers and health plans in the United States, also provides hot links to its members' Web sites (http://www.caqh.org/whoweare_members.html). In many cases, the actual insurer sites contain information similar to that posted on Medicare Part B carrier pages.

The documents posted on the Web sites sometimes are only available in Adobe Acrobat (.pdf) format. A free copy of Adobe Acrobat Reader can be downloaded to view the items. Most Web sites contain a link to the Adobe download site.

In addition, several companies offer online basic coding courses and coding and billing software for purchase. It is possible to do an Internet search for "medical coding" or "coding consultants" to view the products available. Some companies offer demonstration products that can be downloaded for evaluation. Surgeons certainly want to review the products with their coding books in

hand to ensure the accuracy of the material provided. Although the College does not recommend or endorse any of these products, such items may offer cost-effective methods of introducing office staff to the principles of coding and reimbursement.

Reimbursement for fluoroscopy

After July 1, 2001, the College received several inquiries from surgeons' offices regarding an apparent change in Medicare coding rules and reimbursement levels for fluoroscopy (CPT 76000). Part B carriers were no longer reimbursing for the technical component of the procedure and were only paying for the professional component of the service. It turns out that this was a programming error and not a policy change. On November 27, 2002, Medicare notified Part B carriers to update their files to reinstate the technical component reimbursement (Medicare Program Memorandum AB-01-167). The update became effective December 20, 2001. If your office submitted a claim for both the professional and technical components of a fluoroscopy and only received payment for the professional component, resubmit the claim for an adjustment.

HIPAA audit scam

Due to an incident late last year, CMS has requested that all contractors immediately post a notice in their provider bulletins and on their Web sites advising the physicians that there are currently no on-site HIPAA audits being conducted. Surgical practices should never allow any individuals who fail to produce identification and proper documentation from the auditing entity to have access to their computers, medical records, billing information, and so forth. If individuals say they are from Medicare and attempt to gain access to your facilities and/or information without presenting the proper credentials, please contact your Medicare carrier immediately.

Clarification

There has been some confusion regarding some of the information that was published in this column in November 2001. Stereotactic breast biopsy coding may be a little easier to understand in 2002. CPT has added a parenthetical note to code 19295 (Image guided placement, metallic localization

clip, percutaneous, during breast biopsy) informing the user that 19103 (Biopsy of breast: percutaneous, automated vacuum assisted or rotating biopsy device, using image guidance) can be billed in addition to 19295. Unfortunately, this note was not present in 2001. The only reference in 2001 was to code 19102 (Percutaneous needle core biopsy), leaving coders unsure which codes to use when a metallic clip was placed percutaneously and the biopsy was performed percutaneously with the vacuum-assist technology. Users will also find a parenthetical note under code 19103, identifying the appropriate image guidance codes to be used in addition to the biopsy code when appropriate, as well as the reference to the clip placement.

Medicare will continue to deny a percutaneous service when billed with an open procedure such as 19125 (Excision of breast lesion identified by preoperative placement of radiological marker open; single lesion). To avoid unnecessary denials and appeals, watch the narratives closely to ensure that the selected code reports the service being performed. When percutaneous services are performed, select codes with percutaneous in the description of the code; when the service is open, select codes with open in the description of the code. □

College news

April 14-17, 2002

30th Annual Spring Meeting



JAMES BLANK/SAN DIEGO CONV. & VISITORS BUREAU

The American College of Surgeons invites you to attend its 30th Annual Spring Meeting, which will take place April 14-17, 2002, at the Hyatt Regency, San Diego, CA.

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon.

The Advisory Council for General Surgery has planned a program for the 2002 Spring Meeting that will be of interest to all general surgeons. A number of skills-oriented postgraduate courses are scheduled, including Image-Guided Breast Biopsy; Ultrasound for Surgeons; Ultrasound Instructors Course; Breast Ultrasound; Ultrasound in the Acute Setting; Abdominal Ultrasound: Transabdominal/Intraoperative/Laparoscopic; Stereotactic Breast Biopsy; Surgical Education: Principles and Practice; and Advanced Coding for Surgeons.

The Assembly for General Surgeons will focus on health care systems of the twenty-first century

and will discuss the U.S. and United Kingdom health care systems, errors, quality and outcomes, workforce shortages, and professionalism. This general session encourages participation by all in attendance so that the views of practicing general surgeons on these topics can be shared.

Panels on ventral hernia, melanoma for general surgeons, anorectal diseases, vascular access, palliative care in surgery, pancreatitis, and cancer case management will be complemented by popular didactic courses in Minimal Access Surgery; Vascular Surgery 2002; Clinical Problems in Trauma and Emergency Surgery; and Informatics. Technical exhibits from more than 40 companies and highlights from the 2001 Clinical Congress Film Program will round out this exciting spring program.

Make plans now to attend this important meeting. Information regarding the general sessions, postgraduate courses, and registration information will be mailed to Fellows in February. Registration will be available next month online at www.facs.org.

Preliminary program

All general sessions will take place in the Hyatt Regency San Diego, San Diego, CA.

General Sessions

Sunday, April 14

12:45–1:00 pm

Welcome and Opening Remarks

1:00–5:30 pm

General Session (GS01)

Assembly for General Surgeons

A Town Meeting—The 21st Century Health Care System

MODERATOR: George F. Sheldon, MD, FACS, *Chapel Hill, NC*

Monday, April 15

8:30–10:30 am, General Session (GS02)

Ventral Hernia

MODERATOR: Jon M. Greif, DO, FACS, *San Diego, CA*

11:00 am–12:00 noon, General Session (GS03)

Excelsior Surgical Society/Edward D. Churchill Lecture
Your Risky Heuristics and Me: Cognition and Competence

INTRODUCER: Paul Friedman, MD, FACS, *Springfield, MA*

LECTURER: Lawrence W. Way, MD, FACS, *San Francisco, CA*

1:30–5:00 pm, General Session (GS04)

Melanoma for General Surgeons

MODERATOR: J. Michael Guenther, Jr., MD, FACS, *Los Angeles, CA*

7:00–9:30 pm, Film Program (GS05)

Highlights from the 2001 Clinical Congress Film Program in New Orleans

INTRODUCER: Jeffrey H. Peters, MD, FACS, *Los Angeles, CA*

Tuesday, April 16

8:30–10:30 am, General Session (GS06)

Anorectal Diseases

MODERATOR: Charles E. Littlejohn, MD, FACS, *Stamford, CT*

8:30 am–12:00 noon, General Session (GS08)

Palliative Care in Surgery

CO-MODERATORS:

K. Francis Lee, MD, FACS, *Springfield, MA*

Robert A. Milch, MD, FACS, *Cheektowaga, NY*

1:30–5:00 pm, General Session (GS07)

Vascular Access

MODERATOR: A. Frederick Schild, MD, FACS, *Miami, FL*

Wednesday, April 17

9:00 am–12:00 noon, General Session (GS09)

Pancreatitis

MODERATOR: Mark P. Callery, MD, FACS, *Boston, MA*

1:30–4:30 pm, General Session (GS10)

Cancer Case Management Presentations

CO-MODERATORS:

William B. Farrar, MD, FACS, *Columbus, OH*

Alan T. Lefor, MD, FACS, *Los Angeles, CA*

ACS Advisory Council for General Surgery

CHAIR: Paul Friedmann, MD, FACS, *Springfield, MA*

VICE-CHAIR: Joyce A. Majure, MD, FACS, *Lewiston, ID*

Thomas V. Berne, MD, FACS, *Los Angeles, CA*

John L. Cameron, MD, FACS, *Baltimore, MD*

James Cipolla, MD, *Brooklyn, NY*

Richard J. Finley, MD, FACS, *Vancouver, BC*

Nathalie Johnson, MD, FACS, *Portland, OR*

Albert L. Kline, MD, FACS, *Gulfport, MS*

Sally M. Knox, MD, FACS, *Dallas, TX*

Charles D. Mabry, MD, FACS, *Pine Bluff, AR*

John K. MacFarlane, MD, FACS, *Vancouver, BC*

Mark A. Malangoni, MD, FACS, *Cleveland, OH*

Patricia J. Numann, MD, FACS, *Syracuse, NY*

J. Patrick O'Leary, MD, FACS, *New Orleans, LA*

Victor E. Pricolo, MD, FACS, *Providence, RI*

J. David Richardson, MD, FACS, *Louisville, KY*

Charles F. Rinker II, MD, FACS, *Bozeman, MT*

A. Frederick Schild, MD, FACS, *Miami, FL*

Jon S. Thompson, MD, FACS, *Omaha, NE*

Jon A. Van Heerden, MD, FACS, *Rochester, MN*

STAFF:

Paul E. Collicott, MD, FACS, *Chicago, IL*,

Director, Division of Member Services

Mark Peterson, *Chicago, IL*

Administrative Associate

Postgraduate Courses

All Postgraduate Courses will take place at the Hyatt Regency San Diego.

Postgraduate Course 1—Informatics

Sunday, April 14, 8:30 am–12:00 noon
and 1:30–5:00 pm

6 hours (2 sessions); Fee: \$300

CHAIR: David A. Krusch, MD, FACS, *Rochester, NY*

This course will expose the practicing surgeon to a variety of topics centered on the theme of medical informatics and the practical impact that it has on one's surgical practice. Our wide array of experts in the field will discuss issues ranging from implementation and utilization of the electronic medical record, practice management systems, and data security, to the future of wearable computing. The course participants should acquire a working knowledge of the practicality of using information technology to improve their practices, from business aspects to patient care.

Postgraduate Course 2— Image-Guided Breast Biopsy (Core Lectures)

Sunday, April 14, 7:30 am–12:00 noon
4 hours; Fee: \$250

CHAIR: Philip Z. Israel, MD, FACS, *Marietta, GA*

The objective of this course is to teach surgeons how to identify mammographic abnormalities and to recognize when to order additional image studies. Surgeons will learn how to differentiate between benign and malignant lesions and when to recommend close follow-up as opposed to operation. Surgeons will learn how to correlate the mammographic image with the pathologic finding and to implement appropriate clinical pathways. The technique for the performance of stereotactic biopsy and ultrasound-guided biopsy will be reviewed.

Postgraduate Course 3—Surgical Education: Principles and Practice

Sunday, April 14, 8:30 am–12:30 pm
and 2:00–5:00 pm

6 hours (2 sessions); Fee: \$300

CO-CHAIRS: Mary E. Maniscalco-Theberge, MD, FACS, *Reston, VA*

Michael R. Marohn, DO, FACS, *Alexandria, VA*

The objective of this course is to enhance the

teaching skills of surgeons active in student and/or resident teaching. The principles of adult learning, needs assessment, questioning and feedback skills, and performance evaluation will be reviewed. In addition, participants will develop a thorough understanding of the practical applications of these principles, both in and out of the operating room.

Postgraduate Course 4— Ultrasound for Surgeons

Sunday, April 14, 1:00–5:00 pm

4 hours; Fee: \$250

CHAIR: William R. Fry, MD, RVT, FACS, *Colorado Springs, CO*

The objective of this course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. The basic core module or its equivalent is a prerequisite for education in advanced training modules in the management of specific clinical problems.

The basic course is an introduction to ultrasound and does not qualify the surgeon to apply the technique independently. At the conclusion of this course, the surgeon will have completed didactic preparation necessary to undertake ultrasound skills training.

Postgraduate Course 5— Ultrasound Instructors Course

Monday, April 15, 7:30 am–12:00 noon (lectures and workshop)

4 hours; Fee: \$100

CHAIR: Michael R. Marohn, DO, FACS, *Alexandria, VA*

This course is designed to provide the experienced surgeon sonographer with the skills necessary to teach ultrasound to surgical residents at the local level and to practicing surgeons at the national level.

Prerequisite: Approval by National Ultrasound Faculty Vice-Chair for Education; application required. Contact Darrell Sparkman at dsparkman@facs.org for additional information.

Postgraduate Course 6— Breast Ultrasound

Monday, April 15, 8:30 am–12:00 noon
and 1:00–5:00 pm (lectures and workshop)

7 hours (2 sessions); Fee: \$750

CO-CHAIRS:

Richard E. Fine, MD, FACS, *Marietta, GA*

Edgar D. Staren, MD, PhD, FACS, *Toledo, OH*

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live model and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

Prerequisite: Ultrasound for Surgeons (PG 4). If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

Postgraduate Course 7—Minimal Access Surgery

Monday, April 15, 8:30 am–12:00 noon
and 1:30–5:00 pm

6 hours (2 sessions); Fee: \$400

CHAIR: Desmond H. Birkett, MD, FACS, *Burlington, MA*

The objective of this course is to provide practicing general surgeons information on established and emerging minimal access laparoscopic procedures. Topics include the treatment of achalasia, paraesophageal hernia, some of the difficult problems of gastroesophageal reflux disease, laparoscopic management of carcinoma of the colon and inflammatory bowel disease, and hand-assisted laparoscopy. Management of morbid obesity by gastric banding and gastric bypass, hernia repair, and laparoscopic management of solid organ procedures will also be discussed.

Postgraduate Course 8—Ultrasound in the Acute Setting

Monday, April 15, 12:30–6:30 pm (lectures and workshop)

6 hours (2 sessions); Fee: \$750

CHAIR: Heidi L. Frankel, MD, FACS, *New Haven, CT*

The objective of this course is to familiarize the participant with areas of ultrasound frequently used by general surgeons to evaluate patients with acute surgical problems. The participant will learn focused ultrasound examinations through individual

hands-on experience and will acquire an understanding of the essentials of ultrasound technology and physics.

Prerequisite: Ultrasound for Surgeons (PG 4). If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

Postgraduate Course 9—Abdominal Ultrasound: Transabdominal/Intraoperative/Laparoscopic

Tuesday, April 16, 7:30–9:30 am; 10:00 am–12 noon
and 1:00–5:00 pm (lectures and workshop);

Wednesday, April 17, 7:30 am–12 noon (workshop)

12 hours (4 sessions); Fee: \$1,500

CHAIR: Junji Machi, MD, PhD, FACS, *Honolulu, HI*

The objective of this course is to provide the practicing surgeon and surgical resident with advanced education and training in abdominal ultrasound—including transabdominal, intraoperative, and laparoscopic ultrasound—as it is used in the diagnosis and treatment of abdominal diseases. This one-and-a-half-day course will consist of lectures and individual hands-on sessions. Human, live animal, excised liver, and phantom models will be used to develop skills in abdominal ultrasound imaging and ultrasound-guided procedure.

Prerequisite: Ultrasound for Surgeons (PG 4). If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

Postgraduate Course 10—Vascular Surgery 2002

Tuesday, April 16, 8:30 am–12:00 noon
and 1:30–5:00 pm

6 hours (2 sessions); Fee: \$300

CHAIR: Joseph L. Mills, MD, FACS, *Tucson, AZ*

The objective of the first session of this course is to provide an update for the practicing surgeon on the available techniques to improve the quality and outcomes of hemodialysis access surgery and the implications of the recent National Kidney Foundation-Dialysis Outcome Quality Initiatives on the care of patients with end-stage renal disease. The second session will focus on the presentation and management of complications of vascular diseases and the methods and devices used to treat them.

Postgraduate Course 13— Advanced Coding for Surgeons

Tuesday, April 16, 8:30 am–12:00 noon
and 1:30–5:00 pm
6 hours (2 sessions); Fee: \$300
CHAIR: John T. Preskitt, MD, FACS, *Dallas, TX*

The objective of this course is to provide an in-depth discussion of advanced concepts in ICD-9-CM diagnosis coding, CPT surgical coding and modifier use, reporting staged surgeries, consultations, and variables that influence the correct reporting of physician services, including the National Correct Coding Initiative and the impact of carrier medical review policies. The program will include hands-on case coding to ensure that participants can accurately code sample general surgery cases. At the conclusion of this program, participants will: (1) have a clear understanding of diagnostic and procedural codes and payor policies; (2) be able to accurately report patient encounters and procedures which will result in the appropriate reimbursement for surgical practices; and (3) be able to comply with the Office of Inspector General guidelines requiring physician practice compliance in order to prevent submission of erroneous claims to federal health care programs and abusive or fraudulent coding and reimbursement practices. Participants must bring their copies of the 2002 editions of *Current Procedural Terminology* (CPT) and ICD-9-CM to the course. This course is recommended for general surgeons with two years of solid coding experience.

Postgraduate Course 11— Stereotactic Breast Biopsy

Wednesday, April 17, 7:30 am–12 noon and 1:00–5:00 pm (lectures and workshop)
8 hours (2 sessions); Fee: \$750
CHAIR: Darius S. Francescatti, MD, FACS, *Chicago, IL*

The objective of this course is to introduce the surgeon to the principles and practice of stereotactic biopsy as a minimal access means of obtaining tissue

samples for diagnosing indeterminate or suspicious mammographic lesions. An overview of radiation safety issues as related to stereotaxis, as well as the technical efficacy and cost analysis of stereotactic versus other alternatives, will be presented.

Prerequisite: Image-Guided Breast Biopsy (PG 2). If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain it. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

Postgraduate Course 12— Clinical Problems in Trauma and Emergency Surgery

Wednesday, April 17, 8:30 am–12:00 noon
and 1:30–5:00 pm
6 hours (2 sessions); Fee: \$300
CHAIR: L.D. Britt, MD, MPH, FACS, *Norfolk, VA*

The practices of general/trauma surgeons frequently involve a broad range of emergency surgery. The objective of this course is to familiarize participants with a range of acute surgical emergencies, including trauma, vascular, gastrointestinal, and surgical infections. Diagnosis and operative management will be emphasized.

The Spring Meeting will conclude at 5:00 pm on Wednesday, April 17, 2002.

The American College of Surgeons sponsors this conference to promote advances in surgery and other areas of science. The information presented through the programs and exhibits is not verified or endorsed by the American College of Surgeons. Presenters and exhibitors are solely responsible for content.

Registration Form

American College of Surgeons
30th Annual Spring Meeting
April 14–17, 2002
Hyatt Regency San Diego
San Diego, California

Mail registration form to:
American College of Surgeons
PO Box 92340
Chicago, IL 60675-2340
Or fax to: 800/682-0252
Or register online at: www.facs.org

Deadline for advance registration is March 6, 2002. Payment must accompany registration.

Fellowship ID Number	First Name and Initial	Last Name	
Address (number, suite, and street)			
City	State/Province	ZIP/Postal Code	Country

Telephone () Fax () _____

E-mail _____

REGISTRATION FEES: APPROPRIATE STATUS MUST BE CHECKED

	On or Before 3/6	After 3/6
☐ Fellow	No Fee	No Fee
☐ Associate Fellow	No Fee	No Fee
☐ ACS Candidate Group	No Fee	No Fee
☐ Medical Student (with letter of verification)	No Fee	No Fee
☐ Guest Physician	\$375	\$425
☐ Resident (with letter of verification)	\$100	\$125
☐ Allied Health Professional	\$150	\$200
☐ PhD	\$375	\$425
☐ Commercial Press Company: _____	\$125	\$175
☐ Commercial Representative Company: _____	\$375	\$425

POSTGRADUATE COURSE FEES: PLEASE INDICATE SELECTION(S) CLEARLY

☐ PG 1	Informatics	\$300
☐ PG 2	Image-Guided Breast Biopsy	\$250
☐ PG 3	Surgical Education: Principles and Practice	\$300
☐ PG 4	Ultrasound for Surgeons	\$250
☐ PG 5	Ultrasound Instructors Course (approval of National Ultrasound Faculty required)	\$100
☐ PG 6	Breast Ultrasound Prerequisite: Ultrasound for Surgeons (PG 4)	\$750
☐ PG 7	Minimal Access Surgery	\$400
☐ PG 8	Ultrasound in the Acute Setting Prerequisite: Ultrasound for Surgeons (PG 4)	\$750
☐ PG 9	Abdominal Ultrasound Prerequisite: Ultrasound for Surgeons (PG 4)	\$1,500
☐ PG 10	Vascular Surgery 2002	\$300
☐ PG 11	Stereotactic Breast Biopsy Prerequisite: Image-Guided Breast Biopsy (PG 2)	\$750
☐ PG 12	Clinical Problems in Trauma and Emergency Surgery	\$300
☐ PG 13	Advanced Coding for Surgeons	\$300

Note: Additional information
on prerequisites can be
found in the Postgraduate
Course section.

Please Indicate Amount Due:

Registration Fee \$ _____
Postgraduate Course Fee(s) \$ _____
Total Due \$ _____

F O R M C O N T I N U E S O N B A C K

PAYMENT INFORMATION

Payment must accompany your registration. Make checks payable in U.S. funds to:
American College of Surgeons

If paying by credit card, please complete

☐ Visa	☐ MasterCard	☐ American Express																							
Credit Card Number		Exp. Date (mm/yy)																							
<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																				<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td></tr></table>			/		
		/																							
Name on Credit Card																									
Signature																									

SURGICAL SPECIALTY (PLEASE INDICATE)

- ☐ General Surgery (SUR)
- ☐ Cardiothoracic Surgery (THO)
- ☐ Colon and Rectal Surgery (CRS)
- ☐ Gynecology & Obstetrics (OBG)
- ☐ Neurological Surgery (NEU)
- ☐ Ophthalmic Surgery (OPT)
- ☐ Orthopaedic Surgery (ORT)
- ☐ Otorhinolaryngology (ORL)
- ☐ Pediatric Surgery (PED)
- ☐ Plastic and Maxillofacial Surgery (PLA)
- ☐ Urological Surgery (URO)
- ☐ Vascular Surgery (VAS)
- ☐ Other

Americans with Disabilities Act



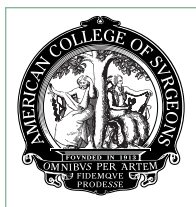
- ☐ Check here if special services are required due to a disability.

Please specify _____

An ACS staff person will contact you.
*Please provide a daytime phone number
or e-mail address:*

phone (_____) _____

e-mail _____



CANCELLATION POLICY

Registration fees will be refunded if a written request is received at the College and postmarked no later than March 6, 2002.

A \$50 handling fee will be retained.
Registrations postmarked after March 6, 2002, will not be eligible for refunds.

Confirmation will be mailed to all registrants.
Please assure legibility prior to mailing/faxing.
Please do not submit repeatedly.

Registration information

Registration includes name badge and entrance to all sessions other than postgraduate courses. Registered attendees may purchase postgraduate course tickets based upon availability. Advance registration is strongly encouraged and open to all physicians and individuals in the health care field. You can register by one of the following methods:

Online: Register online at: www.facs.org. Visa, MasterCard, or American Express payment of all applicable fees must be paid at the time of your online registration.

By fax: Complete the registration form and fax to 800/682-0252 or 312/202-5003. Visa, MasterCard, or American Express payment of applicable fees must be included on your faxed registration. Purchase orders are not accepted. Your registration will not be processed without the appropriate payment information. You do not need to mail the original registration form from this program if you submitted your registration by fax.

By mail: Complete and mail the registration form to: American College of Surgeons, P.O. Box 92340, Chicago, IL 60675-2340. Payment of all applicable fees must accompany your registration.

The deadline for advance registration is March 6, 2002. Registrations received and postmarked after March 6 will be billed according to the fees indicated on the registration form. Formal, written confirmation will be mailed to all advance registrants upon successful processing.

Prior to the meeting, each advance registrant will

receive their official name badge, attendance verification card, and postgraduate course ticket(s), if applicable. Postgraduate course syllabi will be distributed on site in San Diego.

If you are unable to register in advance, bring the completed registration form with proper credentials and payment information, if applicable, to the on-site registration area of the Hyatt Regency San Diego.

Cancellation: Registration fees will be refunded if a written request is received at the College and postmarked no later than March 6, 2002. A \$50 handling fee will be retained. Cancellations received after March 6 will not be eligible for refunds.

Registration location and hours

All advance and on-site registration activity will be held at the Hyatt Regency San Diego as follows:

Sunday, April 14	7:00 am– 5:30 pm
Monday, April 15	7:00 am– 7:00 pm
Tuesday, April 16	7:00 am– 5:00 pm
Wednesday, April 17	7:00 am–12:00 noon

There is no on-site registration fee for Fellows, Associate Fellows, and ACS Candidate Group members. Postgraduate course tickets may be purchased on site in San Diego subject to availability.

Registration fees/credentials

Please note the table below for various registration fees and credentials required for processing your registration.

Registration fees/credentials			
Category	Credentials	On or before 3/6/02	After 3/6/02
Fellow	Current white ID card	No fee	No fee
Associate Fellow	Current yellow ID card	No fee	No fee
Candidate Group	Current blue ID card	No fee	No fee
Guest physician	Medical identification	\$375	\$425
Resident	Letter of verification*	\$100	\$125
Medical student	Letter of verification*	No fee	No fee
PhD	Business card	\$375	\$425
Allied health	Medical identification	\$150	\$200
Commercial press	Business card	\$125	\$175
Commercial representative	Business card	\$375	\$425
*The American College of Surgeons is pleased to offer discounted registration fees for residents and students. Please submit a letter verifying your educational status with your completed registration form to expedite processing. Residents should obtain a letter from their program director, and students should contact their department chairs.			

Postgraduate courses/fees

Course tickets may only be purchased by registered meeting attendees. Each course requires a ticket for admission. Tickets may only be exchanged before the beginning of a course. Seating is limited.

Cancellation: Postgraduate course fees will be refunded if a written request is received by the College and postmarked no later than March 6, 2002. A \$50 handling fee will be retained. Cancellations received after March 6 will not be eligible for refunds. The American College of Surgeons reserves the right to cancel any regularly scheduled session prior to the start of the meeting.

Technical exhibits

To enhance the educational value of the meeting, over 40 companies will display products or services related to the practice of surgery. Your registration includes a reception Monday, April 14, 5:00 to 7:00 pm, in the exhibit hall. Technical exhibits will be open Monday from 12:00 noon to 3:30 pm and from 5:00 to 7:00 pm for the reception. The exhibit hall will be open Tuesday, April 15, from 10:00 am to 3:30 pm.

Accreditation

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

CME credit

The American College of Surgeons designates this educational activity for a maximum of 35 hours in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Audio tapes

Selected postgraduate courses, general sessions, and named lectures will be recorded live and will be available for purchase on audiocassettes. Additional information will be available on site in San Diego at the National Audio Video booth near the registration area.

Location

As California's second largest city and the seventh largest in the U.S., San Diego is a thriving cosmopolitan center with a relaxed atmosphere. Known for its near-idyllic climate, 70 miles of pristine beaches, and array of world-class family attractions, San Diego offers a wide variety of things to see and do, appealing to guests from around the world. Included among San Diego's major attractions are: the world famous San Diego Zoo; Sea World; historic Old Town; the Gaslamp Quarter; and



The Gaslamp Quarter, San Diego, CA.

JEFF GREENBERG/SAN DIEGO CONV. & VISITORS BUREAU

Balboa Park, which offers 15 museums, numerous art galleries, and the Globe Theatres. Just a few miles to the north of the city, La Jolla offers the Scripps Aquarium, Scripps Institute of Oceanography, and the Salk Institute, while the border town of Tijuana, Mexico, provides wonderful bargain shopping.

San Diego is serviced by Lindberg International Airport, which is located three miles from the meeting venue. Information regarding ground transportation will be included with registration confirmation materials.

Hotel reservations

The 30th Annual Spring Meeting will be held at the Hyatt Regency San Diego. Located on San Diego Bay, the Hyatt offers luxurious water-view guest rooms with full amenities, a business center, and a complete fitness center with pool/whirlpool, bike trails, and tennis courts. The hotel's resort-like setting is complemented with shopping, entertainment, and additional dining options located at adjacent Seaport Village. Reservations can be made by calling the hotel directly at the numbers listed below. Please indicate that you will be attending the ACS Spring Meeting in order to obtain the special group rates.

Hyatt Regency San Diego
One Market Place
San Diego, CA 92101
Hotel main phone: 619/232-1234
Hyatt reservations: 800/233-1234
Hotel reservations fax: 619/645-6237
Hotel guest fax: 619/233-6464
ACS group rates: \$213.00 single/double occupancy

Reservations made after the housing deadline of March 18, 2002, or after the room block fills, are subject to space and rate availability. A deposit of one night's stay is required when making your reservation, payable via check or credit card. The deposit is refundable if the reservation is cancelled at least 24 hours prior to 4:00 pm the day before the scheduled arrival date.

Transportation

Special meeting saver airfares are available on United or Delta Airlines. Choose from the following savings options:

- Receive a 5 percent discount off lowest applicable domestic published fares.
- Receive a 10 percent discount off the published unrestricted coach fares.
- Obtain a 5 percent additional discount on the above fares if tickets are purchased at least 60 days in advance.

Area/zone fares based on geographic location are also available with *no Saturday night stay required*. Minimum stay (one to two nights) varies by airline; seven-day advance purchase required. (Zone fares not available through online ticket purchase; please call numbers below).

These special discounts are available by contacting the designated ACS travel agency, I.T.S. Group of ExpoExchange, or by calling either official airline directly (either independently or through a travel agent). Be sure to indicate the name of the meeting to which you will be traveling and refer to the ACS file numbers to obtain the special fares.

United Airlines
800/521-4041
7:00 am–10:00 pm (ET)
ACS File 501CR

Delta Air Lines
800/241-6760
8:30 am–11:00 pm (ET)
ACS File 182140A

I.T.S.
800/621-1083 or 847/940-1176
8:00 am–5:00 pm (M-F, CT)
(\$20 service fee applies)

NEW! Save time and book your travel online through the ACS Web site! Go to www.facs.org for further details.

Study of volunteerism among surgeons

To Fellows of the College:

The promotion of volunteerism has long been an interest of the American College of Surgeons (ACS), but only recently has it become a strategic mission for the College. Over the past two years, the Socioeconomic Issues (SEI) Committee of the Board of Governors has developed a program to discover and promote the provision of volunteer services to those in need locally, nationally, and internationally. Our preliminary data, drawn from interviews, focus groups, and replies from a survey of the Governors, indicate a truly remarkable number of individual surgeons and groups organized to bring surgical care to people in need.

With the support of the Regents, the SEI Committee now seeks to gather information from all ACS Fellows. We will use this information to help the ACS develop policies and services that would facilitate volunteerism among surgeons and to provide a forum for sharing experiences and insights into volunteerism.

PLEASE TAKE A MINUTE TO FILL OUT AND RETURN THE ATTACHED POSTAGE PAID POSTCARD.

We want to hear from you and get your input so we can better understand how we can help. This study is simply meant to gather information—we will not contact you to solicit your involvement in volunteer activities. Thank you in advance. With your input, the ACS can better work for you.



Andrew L. Warshaw, MD, FACS
Chair
Committee on Socioeconomic Issues
ACS Board of Governors

KEEPING CURRENT, from page 27

will have to ascertain the relation of the mass to adjacent structures. In a patient with suspected metastatic cancer, FNA is a sensible choice: It will confirm the presence of malignancy and may suggest a source of the primary cancer. In their newly updated chapter, the authors review not only the logical steps of workup and diagnosis of neck mass, but also the subsequent treatment decisions, including both the surgical and the medical options.

The full text of "Neck Mass" may be viewed online in the physician portion of the WebMD Web site, at www.webmd.com. Click on "ACS Surgery: Principles and Practice."

Looking ahead

New chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in the first part of 2002 include "Open Esophageal Procedures," by Richard Finley, MD, FACS, and John Yee, MD; "Acute Renal Failure," by Anthony A. Meyer, MD, FACS, and Renae Stafford, MD; "Injuries to the Great Vessels of the Abdomen," by David V. Feliciano, MD, FACS; "Jaundice," by Jeffrey Barkun, MD, and Alan Barkun, MD; "GI Endoscopy," by Jeffrey Ponsky, MD, FACS; and "Emergency Department Evaluation of the Patient with Multiple Injuries," by Felix Battistella, MD, FACS. □

2002 Young Surgical Investigators' Conference

March 8-10, 2002

Lansdowne Resort
Conference Center
Leesburg, VA

Sponsored by the Surgical Research
and Education Committee of
the American College of Surgeons

The Surgical Research and Education Committee of the American College of Surgeons has organized the Sixth Biennial Young Surgical Investigators' Conference to assist surgeon-scientists who are entering the process of obtaining extramural, peer-reviewed grant support for their work. The goal of these conferences, held with staff members of the National Institutes of Health (NIH) in attendance, is to introduce young surgeons to the process, the content, the style, and the people involved in successful grant-writing and interactions with the NIH.

The program will include intensive exposure to:

- NIH programs and policies
- Information from NIH Institutes
- What programs are best and available for your research project and how to apply
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Grant-writing strategies
- Mock study sections reviewing model grants

The program and registration form are available on-line at <http://www.facs.org/dept/serd/srec/youngsurg.html>. For further information, contact Ms. Susan Grunwald, Office of Evidence-Based Surgery, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; phone 312/202-5231; fax 312/202-5011; e-mail sgrunwald@facs.org

2002 Travelling Fellow selected

Douglas Tyler, MD, FACS, chief of surgical oncology at Duke University Medical Center, Durham, NC, was selected as the 2002 Australia and New Zealand (ANZ) Chapter of the ACS Travelling Fellow. As the Travelling Fellow, Dr. Tyler will participate in the annual scientific congress of the Royal Australasian College of Surgeons in Adelaide, Australia,

May 12-17, 2002. He will attend the ANZ Chapter meeting during that congress, and will then travel to several surgical centres in Australia and New Zealand.

Requirements for the 2003 Travelling Fellowship appear on page 50 of this month's *Bulletin*, they can also be viewed on the College's Web site, at www.facs.org.



Dr. Tyler

2002 International Guest Scholars selected

Six International Guest Scholarships for 2002 were awarded by the Board of Regents at the 87th annual Clinical Congress. This program enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress, then to tour surgical institutions of their choice in

North America. The program is administered by the College's International Relations Committee. The requirements for applicants for the 2003 International Guest Scholarships appear on page 51.

The 2002 International Guest Scholars are: **Isidoro DiCarlo, MD**, Francavilla di Sicilia, Italy (Abdol Islami Scholar);

Gonzalo A. Fernandez Naone, MD, Montevideo, Uruguay; **Gareth J. Morris-Stiff, MB, BCh, FRCS (Eng)**, Pontypridd, Wales; **William N. Sanchez Maldonado, MD**, Bogota, Colombia; **Christian W. Schinkel, MD**, Munich, Germany; and **Vladislav V. Semiglasov, MD**, St. Petersburg, Russia.

Applications being accepted for research award in academic vascular surgery

The Pacific Vascular Research Foundation is accepting applications for the 2002 Wylie Scholar Award in Academic Vascular Surgery. The award is intended to enhance the career development of academic vascular surgeons with an established research program in vascular disease and is in the amount of \$50,000 per year for three years. Funding for the

second and third years is subject to review of acceptable progress reports.

The candidate must be a vascular surgeon who has completed an accredited residency in general vascular surgery and who holds a full-time appointment at a medical school accredited by the Liaison Committee on Medical Educators in the U.S. or the Committee for

the Accreditation of Canadian Medical Schools in Canada.

Applications are due February 1, 2002, for the award to be granted July 1, 2002. Applications and further information may be obtained by contacting the Pacific Vascular Research Foundation, Wylie Scholar Award, 3627 Sacramento St., San Francisco, CA 94118, e-mail PVRFSF@aol.com.

Credentialing, malpractice key issues at AMA meeting

During the Interim Meeting of the American Medical Association's (AMA) House of Delegates on December 1-5, 2001, the College's delegation was successful in achieving passage of a resolution pertaining to prompt initial credentialing of physicians by managed care plans. This resolution states that Medicare, Medicaid, and managed care organizations should: (1) make final physician credentialing determinations within 45 calendar days of receiving a completed application; (2) grant provisional credentialing pending a final determination if the process exceeds 45 days; and (3) retroactively com-

pensate physicians for services rendered from the date of their application once they are credentialed. The resolution also directed the AMA to develop model state legislation on this issue and to work with state medical associations to achieve its passage.

A dominant issue at the meeting was the growing malpractice crisis, a fact that resulted in the adoption of a resolution that places tort reform, particularly a cap on noneconomic damages, at the top of the AMA's state and federal legislative priority lists. It also calls for a new coalition effort to develop and implement a comprehensive strategic plan

to address all aspects of the crisis. The resolution includes a provision, put forth by the College, to develop and promote a methodology for improving the adequacy of reimbursement for professional liability expenses under federal, state, and private health insurance programs. The College's delegation included Executive Director Thomas R. Russell, MD, FACS, Richard Reiling, MD, FACS, Charles Logan, MD, FACS, Amilu Rothhammer, MD, FACS, and Thomas Whalen, MD, FACS. For more information, contact Jon Sutton at 312/202-5358, or via e-mail at jsutton@facs.org.

Select postgraduate course syllabi now available on CD-ROM

A CD-ROM containing 20 select postgraduate course syllabi from the 2001 Clinical Congress in New Orleans, LA, is now available for purchase through the College's Web site at <http://www.facs.org/members/members.html>. Scroll down the page and click on the "Publications and Services Catalog" link; after entering the catalog, click on the "Keeping Current" link. The CD-ROM may also be ordered by calling ACS Customer Service at 312/202-5474.

The CD-ROM contains syllabi from the following postgraduate courses: Professional Liability

and Risk Management in a Changing Health Care Environment; Head and Neck Surgery; Diseases of the Liver, Biliary Tract, and Pancreas; Vascular Surgery; Thoracic Surgery; Current Controversies in Cancer Management; Gastrointestinal Disease; Minimal Access Surgery; Clinical Update in Trauma; Cardiac Surgery; Laparoscopy and Urology; Surgical Infection and Antibiotics; Breast Disease; Pre- and Postoperative Care (Nutritional Support); Anesthetic Innovations for Improving Surgery and Postoperative Pain Control;

Practical Operating Room Management for Surgeons; Complex Hemangiomas and Vascular Malformations; Perioperative Care of the Anemic Patient; Colon and Rectal Surgery; and The Anatomy and Surgical Correction of Groin and Abdominal Wall Hernias.

The CD-ROM is available for \$35, with an additional charge of \$12 for shipping and handling for international orders. For further information, contact Dawn Pagels, tel. 312/202-5185, or e-mail dpagels@facs.org.

announcing

SESAP 11



the latest word from the
American College of Surgeons

Take a moment from your busy schedule and enroll, using
the easy form below. We'll send you everything you'll
need to maintain your excellent surgical form.

count on knowledge –
for better patient care

✂

NAME _____	
ADDRESS _____	
CITY _____	STATE/PROV. _____ ZIP/POST CODE _____
COUNTRY _____	
TEL () _____	
SPECIALTY _____	



Your enrollment fee includes both book and
CD-ROM formats and 60 hours of category 1
credit if response materials are returned.

status/enrollment fees	amount
☐ I am a FELLOW in good standing of the American College of Surgeons. Fellowship ID# _____	\$345. \$
☐ I am an ASSOCIATE FELLOW in good standing of the American College of Surgeons. Associate Fellowship ID# _____	\$265. \$
☐ I am a PARTICIPANT in the ACS Candidate Group and have paid my current dues. Candidate ID # _____	\$160. \$
☐ I am a RESIDENT in a surgical residency program accredited by the Accreditation Council for Graduate Medical Education and listed in the Graduate Medical Education Directory. A LETTER IS ENCLOSED from my program director or administrator.	\$215. \$
☐ I am none of the above, but wish to enroll.	\$475. \$

Charge my: ☐ VISA ☐ MasterCard ☐ American Express	Subtotal	\$
Card # _____ Exp. Date / _____	Add 8.75% sales tax only for deliveries to IL	\$
Cardholders Signature _____	TOTAL	\$

☐ My check for the amount indicated
\$ _____ is enclosed.
Make check payable
(U.S. currency only) to the:
AMERICAN COLLEGE OF SURGEONS
633 N. Saint Clair St.
Chicago IL 60611-3211

call toll free or fax
(credit card orders only):
tel 800/251-3775
fax 312/202-5005
For more information, visit our
Website www.facs.org

thank you
for participating

2003 Australia and New Zealand Travelling Fellowship available

The International Relations Committee of the American College of Surgeons (ACS) announces the availability of a travelling fellowship, the Australia and New Zealand (ANZ) Chapter of the American College of Surgeons Travelling Fellowship.

Purpose

The purpose of this fellowship is to encourage international exchange of surgical scientific information.

Basic requirements

The fellowship is available to a Fellow of the ACS in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in basic science related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic, personable, and possesses good communication skills.

Activities

The Fellow is required to spend a minimum of two or three weeks in Australia and New Zealand.

- To attend and participate in the Annual Scientific Congress of the Royal Australasian College of Surgeons, which will be held in Brisbane, Queensland (May 5-9, 2003).
- To participate in the formal convocation ceremony of that congress.
- To attend the ANZ Chapter meeting during that congress.
- To visit at least two medical centres (other than the Scientific Congress city) in Australia and New Zealand before or after The Annual Scientific Congress of the Royal Australasian College of Surgeons to lecture and to share clinical and scientific expertise with the local surgeons.

The academic and geographic aspects of the itinerary would be finalized in consultation and mu-

tual agreement between the Fellow and the President or designated representative of the Australia and New Zealand Chapter of the ACS. The surgical centres to be visited would depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Australia and New Zealand.

It is hoped that his/her spouse will accompany the successful applicant. There will be many opportunities for social interaction, as well as these professional activities.

Financial support

The Australia and New Zealand Chapter and the College will provide the sum of \$12,000 U.S. to the successful applicant, who will also be exempted from registration fees for the Annual Scientific Congress. He/she must meet all travel and living expenses. Senior chapter representatives will consult with the Fellow about the centres to be visited in Australia and New Zealand, the local arrangements for each centre, and other advice and recommendations about travel schedules. The Fellow is to make his/her own travel arrangements in North America, as this makes available to him/her reduced fares and travel packages for travel in Australia and New Zealand.

The ACS International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this travelling fellowship may be obtained from the College's Web site (www.facs.org) or by writing to the International Liaison Division, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is April 1, 2002.

The successful applicant and an alternate will be selected and notified in August 2002. The formal announcement of the recipient will be made during the 2002 Clinical Congress of the ACS in San Francisco, CA, October 6-11.

International Guest Scholarships available for 2003

The American College of Surgeons (ACS) offers International Guest Scholarships to competent young surgeons who have demonstrated strong interests in teaching and research. The scholarships, in the amount of \$10,000 each, provide the Scholars with an opportunity to visit clinical and teaching centers in North America and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, former College Director. Recently, a bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment have allowed the College to expand the number and the amount of the scholarship award.

The scholarship requirements are:

- Applicants must be graduates of schools of medicine.
- Applicants must be at least 30 years old, but no older than 41, on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant's country.
- Applicants whose careers are in the developing stage are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College, either from the Web site or in paper format. The application must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.
- Applicants must provide a list of all of their publications and must submit, in addition, three

complete publications (reprints or manuscripts) of their choice from that list.

- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or from a Fellow of the ACS residing in their country. The chair's or the Fellow's letter should include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the recommenders. These letters are to be submitted with the completed application form.

- Applicants may submit a photograph. (Passport size is preferable.)

- The International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.

- Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the Scholarships upon completion of their tours.

- An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with supporting documentation.

The scholarships provide successful applicants with the privilege of participating in the College's annual Clinical Congress in October, with public recognition of their presence. They will receive complimentary admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be available in arranging visits, following the Clinical Congress, to various clinics and universities of their choice.

In order to qualify for consideration by the selection committee, all of the above requirements must be fulfilled.

Formal ACS International Guest Scholar application forms may be obtained from the College's Web site (www.facs.org) or by writing to the International Liaison Division, American College of Surgeons, 633

N. Saint Clair St., Chicago, IL 60611-3211, USA.

Completed application forms for the International Guest Scholarships for the year 2003 and all of the supporting documentation must be received at the office of the International Liaison Division prior to July 1, 2002, in order for an applicant to receive consideration by the selection

committee. All applicants will be notified of the selection committee's decision in November 2002. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

WHAT SURGEONS SHOULD KNOW ABOUT..., from page 11

3351 was introduced in the House as a companion bill by Reps. Michael Bilirakis (R-FL) and Sherrod Brown (D-OH). At press time, the future of this legislation was uncertain. But, in any event, it is clear that the College and all

medical and surgical specialty societies must devote considerable resources this year in a cooperative endeavor to implement substantial changes to a number of fatal flaws in the Medicare payment system. □



ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.

ACS Scholarships, Fellowships, Award available

Resident Research Fellowships, July 1, 2003 - June 30, 2005

The American College of Surgeons (ACS) is offering two-year resident research scholarships. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty.

American College of Surgeons Resident Research Scholarship. These scholarships are supported by the generosity of Fellows, chapters, and friends of the College, to encourage residents to pursue careers in academic surgery.

Ethicon Scholarship of the American College of Surgeons for the Study of Surgical Wound Healing. This scholarship is funded by a grant from Ethicon, Inc., and Ethicon Endo-Surgery to encourage residents to pursue careers in academic surgery. The scholarship is intended primarily to stimulate interest in the healing of soft tissue and minimally invasive surgery. Proposals may include the biology of wound repair, complications of wound repair, or the application of new technologies to clinical problems.

Wyeth-Ayerst Scholarship of the American College of Surgeons. Wyeth-Ayerst Pharmaceuticals has provided an unrestricted educational grant to the ACS to fund a Resident Research Scholarship. The purpose of the scholarship is to provide two years of laboratory experience to residents performing surgical research related to biological and physiological aspects of inflammation.

General policies covering the granting of the ACS Resident Research Scholarships are:

- The applicant must be a Candidate Group member of the College who has completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded, July 1, 2003, and shall not complete formal residency training before June 2005. Scholarships do not support research after completion of the chief residency year.

- The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 2003 through June 2005. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent upon the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Division of the College by May 1, 2004.

- Application for these scholarships may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship/fellowship from another agency or organization, the ACS Resident Research Scholarship will be withdrawn. It is the responsibility of the applicant to notify the Scholarships Division of the College of competing awards.

- The scholarship is \$30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient's institution.

- The scholar is expected to attend the Clinical Congress of the ACS in 2005 to present a report on the research to the Scholarships Committee on October 16, and to receive a certificate at the Annual Meeting of Fellows and Initiates on October 21.

- Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be supervising the applicant's research should be submitted. Only in exceptional circumstances

will more than one scholarship be granted in a single year to applicants from the same institution.

The closing date for receipt of applications is September 1, 2002. Application forms may be

obtained upon request from the Scholarships Division, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211 or from the College's Web site: www.facs.org.

Faculty Research Fellowships, July 1, 2003 - June 30, 2005

The American College of Surgeons (ACS) is offering two-year faculty research fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowship is to assist a surgeon in the establishment of a new and independent research program. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is \$40,000 per year for each of two years, to support the research.

Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons. One of the fellowships is named to honor Franklin H. Martin, MD, FACS, founder of the American College of Surgeons.

General policies covering the granting of the American College of Surgeons Faculty Research Fellowships are:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient's institution.

- Preference will be given to applicants who are not current recipients of major research

grants. Application for this fellowship may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship, fellowship, or research career development award from another agency or organization, the ACS Faculty Research Fellowship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Division of the College of competing awards.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the senior investigator (if applicable) supervising the applicant's research effort should be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

- A minimum of 50 percent of the fellow's time will be spent in the research proposed in the application.

- The Fellow is expected to attend the Clinical Congress of the ACS in 2005 to present a report to the Scholarships Committee on October 16, and to receive a certificate at the Annual Meeting of Fellows and Initiates on October 21.

The closing date for receipt of applications is November 1, 2002. Application forms may be obtained upon request from the Scholarships Division, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College's Web site: www.facs.org.

American College of Surgeons George H. A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award, July 1, 2003 - June 30, 2008

This award is developed through the generosity of The Clowes Fund, Inc., of Indianapolis, IN. The purpose of the award is to provide five years of support for the research of a promising young surgical investigator. The award consists of a grant of \$40,000 for each of five years and is not renewable thereafter.

General policies concerning the granting of the George H. A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award are:

- The award is restricted to a Fellow or Associate Fellow of the College who has completed specialty training in a residency or an accredited fellowship in general surgery or a surgical specialty within the preceding seven years and has received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. The applicant's academic appointment may not be above the level of assistant professor. Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.

- The award may be used for salary support or other purposes at the discretion of the recipient and the institution. Indirect costs are not paid to the recipient or to the recipient's institution.

- The American College of Surgeons (ACS) Scholarships Committee will look favorably upon applicants who have received investigator-initiated, peer-reviewed research awards (for example, NIH R01 grants). The committee will not consider applicants who have received research career development type awards from either the National Institutes of Health (NIH), the American Heart Association, or other funding agencies. Also, the recipient may not receive another career development award during the five-year period of support. It is the responsibility of the recipient to notify the Scholarships Division of the College if another source of scholarship/fellowship funding is received.

- Approval of the application is required from the administration (dean or fiscal officer) and the head of the applicant's department or administrative unit. This approval would involve a commitment to continuation of the academic position and facilities for research during the entire period of the award. Furthermore, it must be assured that at least 50 percent of the applicant's time will be spent in the research proposed in the application.

- The applicant must submit a detailed research plan and propose a budget for the five-year period of the award. The applicant also is required to submit a cover letter of approximately 400 words that describes the career objectives, how these career objectives will be achieved, and how the research protocol furthers the applicant's career development. The Scholarships Committee of the College requires an annual progress report from the recipient on which annual renewal is based.

- While holding the award, the recipient is expected to attend the Clinical Congress of the ACS in 2004, 2006, and 2008 to present reports to the Scholarships Committee.

- Upon completion of the five-year funding period, the recipient will be required to submit a summary of research progress and to provide information regarding current academic rank, sources of research support, and future plans.

The closing date for receipt of completed applications is August 1, 2002.

Application forms may be obtained upon request from the Scholarships Division, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College's Web site: www.facs.org.

Contributions to the 2002 Surgical Forum are requested

Abstract deadline: March 1, 2002

Congress: October 6- 11, San Francisco, CA

The Committee for the Forum on Fundamental Surgical Problems invites young surgical investigators to submit abstracts to be considered for presentation during the Surgical Forum at the 2002 Clinical Congress in San Francisco, October 6-11. Preparation of the Forum program is achieved entirely through the review of abstracts of papers reporting original work performed by young surgical investigators. Abstracts that are accepted will appear in a supplement of the *Journal of the American College of Surgeons (JACS)*, a publication recognized by *Index Medicus*. In addition, authors whose abstracts are accepted for the program will be expected to publish their extended abstracts in the *Owen H. Wangensteen Surgical Forum Volume LIII*, which will be available in time for purchase at the Clinical Congress. Full manuscripts may be subsequently submitted to *JACS*, or other journals.

Abstracts received on time and in the prescribed form noted below are reviewed. *Abstracts not received on time or not **exactly** as prescribed will not be considered.* Please read and follow the regulations and specifications carefully. Proofread the abstracts; they cannot be resubmitted for corrections or alterations.

Abstracts are reviewed and selected by the Forum Committee, with each surgical specialty topic being reviewed by appropriate specialty members. General abstracts are graded by committee members most familiar with the abstract's designated category. Following the grading, the full committee meets to select the work to be presented at the Congress. The committee's selections are final.

Notice of acceptance or rejection will be mailed to the principal author of each abstract by May 1. The acceptance notice designates the session where the paper is to be presented and provides

information regarding presentation and the preparation of the extended abstract for publication in the *Surgical Forum Volume LIII*.

Please do not call the Forum office; the staff is unable to acknowledge receipt of abstracts, is not permitted to alter abstracts in any manner, and cannot release the results of the Forum Committee's selections.

Regulations for submitting an abstract

The Owen H. Wangensteen Forum on Fundamental Surgical Problems requires that any investigator who wishes research to be considered for presentation must comply with the instructions concerning the preparation and submission of abstracts.

1. Abstracts are due in the Surgical Forum office no later than March 1, 2002. Submission of an abstract signifies the intent of its principal and associated authors to present the paper at the Surgical Forum, if it is accepted.

2. The abstract must present original research, with the understanding that the research will be presented for the first time at the Forum. *The principal author is responsible for making certain that the paper submitted contains no material that has been published elsewhere prior to presentation at the Surgical Forum. In addition, the principal author is responsible for informing the Forum Committee if the abstract or the paper has been or is to be presented in total or in part at any regional or national meeting prior to the Clinical Congress of the American College of Surgeons; this is cause for exclusion of the paper from the Forum.* Discretionary consideration will be given to papers for which abstracts may have been published outside the U.S. and Canada; principal authors are nonetheless bound to inform the Committee of such abstract

publication *via e-mail* at surgforum@facs.org.

3. The principal (first-named) author must be a young surgical investigator. Older, established surgeons may be included as co-authors, but not as the principal author of an abstract. Please limit the number of co-authors to nine persons.

4. An author may submit only two abstracts as the principal author, and only one will be selected for presentation. Principal authors submitting two abstracts should submit an e-mail stating the titles, categories, and institution affiliation to: surgforum@facs.org.

5. *The principal author may not be changed after an abstract is submitted; co-authors cannot be added or deleted.*

6. Each abstract should be a concise report summarizing work done and in progress. The title of the abstract should be brief, but long enough to identify clearly the nature of the study. The body of the abstract should clearly state the reason for doing the study and include a brief description of methods, the exact results obtained, and the conclusions reached.

It is essential that the abstract present objective data and an accurate analysis of the results. It must be clear that sufficient evidence has been found to support the conclusions. Vague descriptions and promises to present additional information will result in almost certain rejection.

Abstracts should not include unnecessary material such as historical reference, controversial discussion, bibliographies, and review of the literature. Abstracts should be prepared and edited carefully.

7. The extended abstract submitted for publication in the *Surgical Forum Volume LIII* must accurately reflect the significant substance and conclusions represented in the initial *abstract* accepted by the Surgical Forum Committee. If changes in the substance or conclusions in the *abstract* would be necessary for publication of the extended abstract, the submission should be withdrawn by the author(s).

Specifications for the abstract

1. Abstracts for the Surgical Forum Program will be accepted **ONLY** via Internet submission at: <http://web.facs.org/surgicalforum/abstract.cfm>. Submit a complete version of the abstract and one blinded version bearing only the title and

the body of the abstract (omit identifying author information). The complete and blinded versions should be submitted as separate files. Submitted abstracts must contain the **ENTIRE** title in the file name and indicate which file is the blinded version at the end of the filename, i.e., "(title of abstract)blindvers.wpd" (or 'blindvers.doc' etc.).

2. Each abstract must be confined to **one side of one 8-1/2" x 11" page, contain no more than 30 lines of text and a maximum of 250 words**. This includes title, text, authors, and mailing information.

3. Allow a **1-1/2" margin** on the left side, and a **1/2" margin** on all other sides of the page.

4. At the top of the page, the full title of the abstract should be typed with initial capitals. The title should be single-spaced.

5. All abstracts must be designated for one of the categories listed below. The author must choose the category most appropriate for his or her abstract and type the category in the upper right-hand margin of the abstract. The categories are: Alimentary (includes liver, pancreas, biliary tract); Cardiac; Thoracic; Critical Care (includes metabolism, infection, nutrition, blood, endocrine); Surgical Oncology and Associated Immunology; Transplantation and Associated Immunology; Gynecology and Obstetrics; Neurological Surgery; Ophthalmology; Orthopaedic Surgery; Otorhinolaryngology; Pediatric Surgery; Plastic Surgery (includes wound healing, burns); Quality, Outcomes, and Cost; Reproductive Biology and Related Endocrinology; Urology; and Vascular Surgery.

The author may, in addition, designate a second category for the abstract. The second category may be selected from the list above, or may be created by the author. Designation of a second category for any abstract is at the author's discretion.

6. Leave a double space after the title. The body of the abstract must be **double-spaced**. Use a 12-point font or larger, and no more than 16 characters per inch. Organize the abstract with the following headings (non-indented): **INTRODUCTION** (include the reason or rationale for the study, as well as the hypothesis being tested or objective of the study); **METHODS** (include a brief notation of the statistical methods

employed); RESULTS (tables should be single spaced, using the same font as in the body of the abstract; graphs or figures must be clearly legible and contain legends or notations no smaller than 20 characters per inch); and CONCLUSIONS.

7. Leave a double space after the body of the abstract and list the full names and all academic degrees of all authors, followed by the institution from which the work originates. List the institution first, followed by the mailing address and daytime telephone number of the *principal author* or designated contact person in sufficient detail to ensure prompt delivery of communication. The mailing address should be accurate for correspondence in *May*. If the principal author anticipates an address or institutional change

during that time, provide a mailing address and/or contact person that will ensure prompt receipt of communications from the Surgical Forum Committee. Single-spacing should be used for this information. Changes in authorship will not be accepted. PLEASE NOTE: *Only one institution will be published. Contributors (financial, material, laboratory space, etc.) to the research will not be published.*

8. Abstracts are to be submitted no later than **March 1, 2002**. For further instructions or clarification, please forward your e-mail request to: surgforum@facs.org.

9. Abstracts submitted via fax transmittal are unacceptable.

10. Abstracts are **not** to be submitted to the chair or to members of the Surgical Forum Committee.

Trauma committees sponsor standards course

The Western States Committees on Trauma will sponsor a course titled Maintaining Standards in an Era of Crises, on March 25-27. The program will take place at Caesars Palace in Las Vegas, NV.

Kenneth L. Mattox, MD, FACS, is the program director, and the program committee includes Mary K. Allen, David B. Hoyt, MD, FACS, M. Margaret Knudson, MD, FACS, Norman E. McSwain, Jr., MD, FACS, and Donald D. Trunkey, MD, FACS.

The program objectives are to:

1. Identify issues in the management of grade V abdominal and extremity injuries.
2. Suggest innovative treatment modalities for the management of the injured patient in the ICU.
3. Describe the state of trauma care in 2002.

4. Discuss the challenges facing the trauma practitioner who is managing cases that involve difficult to expose trauma, such as tibial trifurcation, thoracic outlet, and iliac vascular injuries.

5. Apply concepts from trauma case studies to the practice setting.

6. Discuss the impact of a severe external disaster on trauma systems.

7. Describe surgical strategies for difficult trauma injuries, including the three-cavity injury, splenic salvage, and indications for thoracotomy.

8. Relate the effect of unusual circumstances to the management of common traumatic injuries.

9. Identify state-of-the-art techniques and advances in technology for the management of a variety of issues, including

pain management, wound closure, transmediastinal gunshot wounds, and hemorrhage control in pelvic fractures.

10. Describe ethical and practice issues facing the trauma practitioner.

11. Discuss the difficulty of maintaining practice standards in an era of nursing/staff shortages, barriers to research, and regulatory restrictions.

12. Compare spiral-enhanced CT with arteriogram in the management of a dissecting thoracic aorta.

13. Describe state-of-the-art treatment strategies for fluid resuscitation.

Complete course information can be viewed on the American College of Surgeons Web site (www.facs.org/dept/trauma/cme/traumtgs.html). For further information contact the ACS Trauma Office at 312/202-5342.



American College of Surgeons at www.facs.org

MEMBERS ONLY



Now ACS Fellows can do all of these things ONLINE:

Change your
address &
contact info

Update your
professional/
academic
information

Update other
practice
information

Pay your
dues

Just go to www.facs.org, and click on the **Members Only** link. There you can **Access the Fellowship Database** by entering your eight-digit **Fellowship ID number** (found on your Fellowship ID card) and your last name.

There's no need to contact the American College of Surgeons—your membership record is automatically updated for all ACS mailings, including the *Bulletin* and the *Journal of the American College of Surgeons*.

You can also pay your dues online and search for contact information on other Fellows in the database.

PDAS, from page 15

to Dr. Hey's MDeverywhere, surgeons can get wireless charge capture software from MedCompanion, inpatient billing and tracking and coding through PocketMed™ or Pocket Patient Billing, a Web-based transaction service through PulseMD, and charting programs via Digital Assist and Medical ChartWriter.

Some of these programs are designed to work on a particular type of PDA—usually the Palm Pilot, which runs on the Palm Operating Systems (Palm OS)—and they typically require eight megabytes of memory, Dr. Tuchler said. Surgeons also can choose between PDAs that have black-and-white or color screens and devices that can be fitted with accessories, such as a digital camera or scanner and expanded memory.

How to choose? Dr. Tuchler suggests that surgeons who are afraid of making an investment in

technology they may not use try an entry-level unit, which costs about \$120, join a physicians' bulletin board and chat room to learn how other surgeons use PDAs, and check out some of the medical Web sites that provide free software. Above all, he said, "don't be afraid to give it a try." Surgeons who are anything like Dr. Tuchler will find that "once you use it, you'll be afraid to leave the house without it." Q

This article was generated through efforts of the Board of Regents' Committee on Informatics. Member of the committee believe that this and other articles published in the *Bulletin* will serve to alert Fellows of the College to and inform them about trends in information technology that will help them simplify the administrative burdens of surgical practice, heighten their use of online and other innovative approaches to CME, and enhance their ability to improve patient care.

AMERICAN COLLEGE OF SURGEONS OFFICIAL JEWELRY & ACCESSORIES

designed, crafted and produced exclusively by Jim Henry, Inc.

World Class Quality
not just a slogan — it's our promise

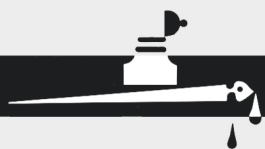
#S15
#S1
#S2
#S16A
#S17
#S18
#S19
#S3
#S4
#S14

Designed expressly for the American College of Surgeons, these emblematic items are crafted to perfection in the Jim Henry tradition of excellence.

TIE TAC/LAPEL PIN		MINIATURE CHARM		DIPLOMA PLAQUE	
#S1 Dbl. Gold Filled	\$45	(Not Shown)		#S18 Satin Brass	\$225
#S2 Solid 14K Gold	\$125	#S11 Dbl. Gold Filled	\$45	#S19 Silver Finish	\$225
CUFF LINKS (Not Shown)		#S12 Solid 14K Gold	\$125	8-1/2" x 12" metal plaque on 11" x 14-1/2" walnut. Specify name, day, month, year elected.	
#S3 Dbl. Gold Filled	\$125	MONEY CLIP (Not Shown)		WOMAN'S BOW TIE (PRETIED) (Not Shown)	
#S4 Solid 14K Gold	\$325	#S13 Gold Filled Emblem	\$50	#S20 Dark Blue	\$35
KEY (Not Shown)		RING		#S21 Maroon	\$35
#S5 Dbl. Gold Filled	\$85	#S14 Solid 14K Gold	\$750	MAN'S BOW TIE (UNTIED) (Not Shown)	
#S6 Solid 14K Gold	\$200	(Indicate finger size)		#S22 Dark Blue	\$35
MINIATURE KEY (Not Shown)		TIE BAR		#S23 Maroon	\$35
#S7 Dbl. Gold Filled	\$75	#S15 Gold Filled Emblem	\$50		
#S8 Solid 14K Gold	\$150	NECKTIE			
CHARM (Not Shown)		#S16A Dark Blue	\$35		
#S9 Dbl. Gold Filled	\$50	#S16B Med. Lt. Blue	\$35		
#S10 Solid 14K Gold	\$175	#S17 Maroon	\$35		

- Please use model # and item description when ordering.
- Include payment with order.
- VISA & MasterCard accepted.
- Prices subject to major changes in gold prices.
- Send order direct to Jim Henry Inc.
- ILLINOIS residents - add 6 3/4% sales tax.

JIM HENRY, INC.
435 - 37th Avenue, St. Charles, Illinois 60174
Phone: 630/584-6500 FAX 630/584-3036



Letters

The following comments were received in the mail or via e-mail regarding recent articles in the Bulletin and the "From my perspective" columns written by ACS Executive Director Thomas R. Russell, MD, FACS.

9/11/01

Your editorial in the October *Bulletin* about the World Trade Center was superb. It was clear, perceptive, and eloquent. Enclosing selective comments from "Surgeons USA" was also an excellent idea. They clearly reflected the marvelous American spirit that makes this such a great country.

**Frank C. Spencer,
MD, FACS**

War on drugs

Those of us old enough to remember will chuckle reading the arguments for or against drug legalization in the October 2001 *Bulletin*. They sound like faint echoes of arguments advanced and dealt with 30 years ago in the bible on the subject—the extensive 620-page report by the Consumers Union (E.M. Brecher and others: *Licit and Illicit Drugs, The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marijuana—Including Caffeine, Nicotine, and Alcohol*. Boston, MA and Toronto, ON: Little Brown and Co., 1972).

As someone described at the time: "This report, five years in the making, was a massive study of the pharmacology, sociology, and history of mind-affecting drugs in our society, and of our social and legal responses to these drugs and their users. It

devotes a section to each common drug delineating its origin, patterns of use, pharmacology, cultural traditions, its licit and illicit uses by Americans and its legal history. A meticulously documented and researched compendium of accurate and complete information, it remains unparalleled in dispelling the rumors and misrepresentations that have so long affected our policies toward drugs."

This document should be required reading for every medical student, physician, surgeon, sociologist, and politician. Its conclusions are very much in agreement with those of Dr. Roe as it takes on squarely every argument raised by Dr. Mabry.

I well remember the impression it made at the time. I can heartily recommend it to anyone interested in the subject.

**Henry Gans,
MD, PhD, FACS**

Wn regard to the excellent articles on illegal drugs written by Drs. Roe and Mabry: the *Independent* newspaper in London, England, reported a study by seven leading industrial nations that revealed that the illegal drug business was the third largest economy in the world today. It flourishes because it pays!

The illegal drug business has been demonized by society, many elements of which prosper because it is there. For example, the producers and the marketers profit, as do the legal system, the politicians, the media, medicine, bankers (\$120 billion is laundered each year), the church (which has declared illegal drugs sinful), and the gov-

ernment—which perpetuates a war we have lost.

Drugs are easily available in any American school or prison, as well as on the street. Most users are adult recreational users, much as with alcohol. Prohibition was a proven failure. Expensive illegal drugs cause much crime, particularly by minorities, which would disappear with decriminalization.

It is time for the U.S. to face reality. The law should be changed, as Europe is beginning to do.

**Donald G. Blain,
MD, FACS**

Congratulations for allowing the "street drug" issue to be discussed/debated in the *Bulletin*. Knowing that change can only

Correction

In the November 2001 article, "State legislatures 2001: The year in review," it was noted that the state of Alabama releases to the public physician information on malpractice. Alabama does not release this information, and we regret this error. Rather, Arizona provides malpractice information within five years of settlement of a claim through the AIM DocFinder Web site (www.docfinder.org), and Florida discloses claims exceeding \$5,000 within the past 10 years through its Health Licensee and Continuing Education Providers Information Web site (<http://www.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP>).

be effected by young minds that mature and impose their beliefs, I have been proselytizing to my medical students and surgical residents the rationale for legalizing street drugs for over 30 years.

Most of the medical cost due to heroin or similar drug use relates to the infectious sequelae of contaminated injectates that cause abscesses, arterial mycotic aneurysm, deep venous thrombosis, venous aneurysm, diffuse cellulitis, postphlebotic limb, pulmonary abscesses, and endocarditis with consequent multi-organ abscesses, including splenic abscesses and cerebral abscesses.

These infectious sequelae would be totally eliminated by the proper pharmaceutical preparation of these agents, whose strength would be correctly identified in order to prevent overdosing. In contrast, the detrimental effects of cocaine and like drugs result from the intense vasoconstriction that disrupts the metabolic activities of many different organs, resulting in severe illness or death. Many of these complications, though not all, could be circumvented by having the appropriate dosage level on vials that are properly prepared by our pharmaceutical industry.

The tremendous reduction in the cost of drug usage brought about by the preparation and distribution of these drugs by legitimate industry would eliminate the need for the current intense level of profitable marketing and distribution by the "street industry," which equals or even exceeds in efficiency the

best corporations in America. Once these drugs are legalized, the tremendous brainpower of this illegal industry would be redirected toward what would now be more profitable legitimate industries.

Neither Dr. Roe nor Dr. Mabry focuses on the most important cost of our ineffective and costly drug policy. Economists emphasize that the redistribution of monies within our borders may alter the financial well-being of individuals within our society, but will really not have any detrimental effect on the economic well-being of America.

The most important cost of this ineffective policy of "criminalization" has been the loss of respect for the ideals for which America stands. Young children in all neighborhoods know which "crack houses" are safe because of bribes that extend up through the highest levels of our law enforcement system. Many talented teenagers recognize that the most "capitalistic" way to quickly gain financial independence is to become involved in this illicit industry. Young Americans finally earning a decent legal wage seek ways to avoid paying income taxes, following the examples of their former colleagues who have profited from this huge illicit industry. How can a mature country whose legal system is based on the American adaptation of English common law continue to flourish when our young people observe this flaunting of the law at such an early age?

Now we read in the newspapers that the funding for the September 11 attack on America

came primarily from the profits of the drug trade from Afghanistan. Quite frankly, this dumb son of immigrant farmers who engendered in me a love for America doesn't understand how the Physician Leadership on National Drug Policy can continue to procrastinate in their moral and American obligation to promote complete and total legalization of street drugs.

This American hopes that the "distinguished Fellows of the College"—Drs. Claude Organ, Seymour Schwartz, and Donald Trunkey, as cited by Dr. Mabry—will pick up the gauntlet and lead us to the victory that the legalization of street drugs would engender.

**Charles E. Lucas,
MD, FACS**

I applaud your publishing Dr. Roe's enlightened article about the war on drugs in which he advocates legalization. The origin of the prohibition of drugs stems from the work of Harry Anslinger, a man with no scientific background to speak of, who convinced a gullible public that the wily Chinese were using opiates to seduce innocent white women. It was this sort of mind-set that helped to create the Oriental Exclusion Act, of which the U.S. is now understandably ashamed.

The prohibition of alcohol was the catalyst for the creation of organized crime in this country. The prohibition of narcotics has financed, among other things, international terrorism by creating massive fortunes for the smugglers and their friends in governments inimical to the U.S.

I do not advocate the recreational use of narcotics, and I recognize that addiction is a problem for some users, but I cannot understand why the lessons of the prohibition of alcohol haven't rubbed off on people with Dr. Mabry's point of view. The "drug warriors" have instead lied to the country about "gateway" drugs and the instant addicting power of crack cocaine, for example.

We now have a good idea that the inflated price of "illegal" opiates is helping to finance Osama bin Laden and his terrorists—another reason for doing away with the "War on Drugs," which, in fact, was lost many years ago.

**Joseph R. Barrie,
MD, FACS**

I read your excellent October 2001 issue replete with testimonials by Fellows ready to volunteer time and talent to the New York/Pentagon tragedies. Men and women like this are the heart and soul of America and are the stuff that will carry us through this crisis.

In that same issue was the "debate" on "Physicians and the War on Drugs" with Benson Roe, MD, FACS, opting for legality, and Charles Mabry, MD, FACS, asking for continued efforts at control and eradication. In none of the arguments did I see a reference to the unborn child.

In 1992, after opting for early retirement, my wife and I adopted, in the delivery room, a healthy nine-pound baby boy, born to a perky college kid. HIV, hepatitis, family screens, and interviews were all most favorable. The boy grew and devel-

oped into a bright, personable, athletic, and handsome young five-year-old, at which time his personality began to change, and at age six he was diagnosed as having severe attention deficit hyperactivity disorder with associated oppositional defiant disorder.

As a surgeon, this mental illness thing hit me hard, as it became obvious that it was not something "I could fix, quickly." Now nine, he requires medication five times a day to function and there is no certainty he will outgrow this problem. You see, we found that his birth mother was using cocaine during high school and on many occasions during this pregnancy. How sad, and how those choices now hurt this sweet child.

In Ira Chasnoff, MD's, classic book, *The Nature of Nurture*, published in 2001, there is this simple statement: "Children prenatally exposed to drugs and alcohol demonstrated consistent behavioral difficulties, higher levels of anxiety, social problems, thought problems, attention problems, delinquent behavior and aggressive behavior." We have seen all of these. His work at the University of Illinois College of Medicine related to the field of maternal drug use problems and its subsequent effect on the newborn child and adolescent are worthy of our attention, as, heretofore, the cause of some of these problems as been denied, buried, and swept under the rug.

So, Dr. Roe, despite all you taught me during my year as your cardiac fellow, on this point you are mistaken, and tragically misinformed. Your opinions

might change quickly if you could see the devastation that hard drug use inflicts on kids today. Leave your home and come to the real world. Our little third-grader is not alone. There are four others like him (out of 20), all with drug-pregnancy mothers, in his third-grade class at Black Oak. Only recently have psychiatrists and others faced up to the real cause of today's children's attention and performance difficulties, which 40 years ago were virtually unknown.

I hope that these kids can overcome this in order to be capable and trained enough to e-mail their willingness to volunteer their talents when and if their generation is tested. I am proud to have this "burden" to carry, and my wife and I feel as if we were chosen to rescue this incredibly talented but wounded child. If I succeed in building a real man out of this boy, as I believe we can, it will dwarf all of my other, not insignificant, life accomplishments. Drugs hurt kids. Think about it.

And please, no rebuttal from Dr. Roe unless he wants to come visit us and see for himself what maternal drug use can do. Legalize it so more kids can be affected? God forbid.

**John N. Baldwin,
MD, FACS**

Medical meetings

I enjoyed your "From my perspective" as usual. I agree with you completely. The College must be the educational leader on the subject of unconventional civilian disasters. The average surgeon needs direction for them to assume local leadership

roles. I particularly was impressed with the report from the Board of Governors. I liked their specifics.

The article generated from Dr. Baker's address to the Chicago Surgical Society regarding the value of medical meetings is very contemporary and pertinent. Apathy is a problem in local CME and has been a major concern in getting new young surgeons in the Texas Surgical Society and the North Texas Chapter of the American College of Surgeons. I remember when I was on the membership committee of the Western Surgical Association, we had a major drive to get new members from private practice, and they were difficult to recruit due to lack of interest. This problem needs to be continually addressed if surgical organizations are going to remain viable.

Keep up the good work.

Robert Turner, MD, FACS

Dr. Baker's article in the November *Bulletin* is excellent and very special. There is no substitute for the "human touch" in so many things in life. It cannot be replaced by e-mail, fax, etc.

It was fun to read of the commentaries of many of my teachers—Bob Baker, Freeark, Yao, and cigar-chompin' Ken Printen.

The article reminded me of enduring friendships hatched at medical meetings. One of the great spin-offs is the ability to pick up the phone, call a friend/colleague, and ask "What do you think about this?" Our "Rolodexes" should get thicker as we go on. We can develop a

stable of "consultants" and friends that is incomparable.

Thank you, Dr. Baker.

Robert Kotler, MD, FACS

I have always enjoyed the *Bulletin* and find it to be a great source of information that is not available elsewhere. Two articles in the November 2001 issue caught my eye and provoked this missive.

The writings of Dr. William Baker and Drs. Howisey/Durtschi seemed particularly "real world" and current. My meeting attendance has been extensive over the years, making Dr. Baker's studied analysis especially meaningful to me. As much as I use and enjoy the computer, it is depersonalizing and isolating. The give-and-take of personal encounter is a truly human endeavor that I feel not only aids the collegiality of our profession, but also pays out in our patient and family interactions.

The pragmatic approach to current practice problem-solving in Washington State is laudable. This proactive solution seems far more result-oriented than the surgeon's lounge whining that is so commonplace.

I commend the *Bulletin* for publishing such thoughtful and insightful treatises as these.

LaMar S. McGinnis, MD, FACS

Serendipity

Recent dramatic world events prompt this letter. I enjoyed Dr. James Neely's article on serendipity in the February 2001 issue of the *Bulletin*. For my part, I have had one such revelation

that was for me a moment of serendipity.

In 1947 as a young graduate I was medical officer on an expedition to the Antarctic. We used huskies for sled transport. The huskies would fight among themselves, causing lacerations that invariably became badly infected with regional lymphadenitis and abscesses. I found that by immediate suturing of the wounds the infection was prevented.

Many years later I was lecturing on frostbite and I suddenly realized that the suturing of the wounds in the husky dogs prevented the blood- and serum-soaked wounds from getting frostbite with subsequent necrosis and infection. I followed this realization up with a series of experiments on rats with standardized ragged lacerations that were sutured or left open and then frozen solid. Suturing allowed rapid healing while lacerations left open developed necrosis and delayed healing. It was stressed that in human practice cleansing and debridement of wounds in a suitable facility should always be done. These findings were published (*Canadian Journal of Surgery*, 18:146-148, 1975).

With a war in the northern Afghanistan mountains in winter imminent, the principle of preventing frostbite in wounds becomes important.

A.R.C. Butson, MD, FACS, FRCSC

Next month in *JACS*

The February issue of the *Journal of the American College of Surgeons* will feature:

Presidential Address:

- Medicine, Government, and Capitalism

Original scientific articles:

- Screening for Pelvic Fractures
- Neoadjuvant Therapy for Rectal Cancer

Collective review:

- Genetic Changes in Breast Tumorigenesis

What's New in Surgery:

- General Surgery: Burns and Metabolism
 - Vascular Surgery
-